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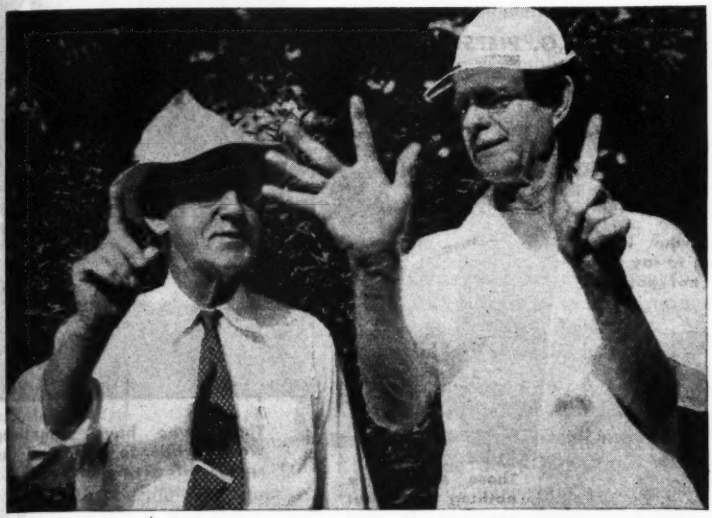
Picture of the Month



HOLE-IN-ONE champion J. H. Phillips, a dentist of Nashville, Tennessee, holds up six fingers to show golf Pro George Livingston the number of holes in one he has scored. (See DENTISTS IN THE NEWS) Mr. Livingston can claim only one hole in one.—*Nashville (Tennessee) Tennessean Photograph, submitted by Johnson G. McDowell, D.D.S.*

Ten dollars will be paid for the picture used in this department each month. Send gloss prints with return postage to Oral Hygiene, 708 Church Street, Evanston, Illinois.

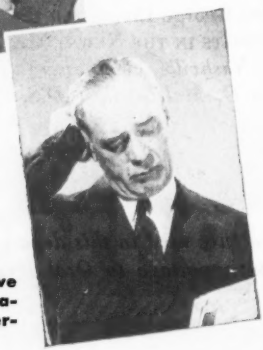
Is There Profit in Your Voice?

By ALBERT G. PIETSCH, D.D.S.

Those who have something worth while to say, and can speak effectively (orators).

Those who have nothing to say and know not how to say it.

Those who have nothing to say but can say it well (certain politicians).



Those who have valuable information but a blundering delivery.

IT WAS unusual. It was so excellent you wanted to stand and cheer while applauding for the program speaker at the county dental meeting. The information was well planned; ideas were presented clearly; and, above all, his voice had that all-important tone quality which arouses and holds the attention of an audience.

Unfortunately, only about 25 per cent of the members of the dental society attended the meeting. This was not unusual. On occasion, when a well-known expert was scheduled to speak, the attend-

ance would comprise a third of the membership list. But, otherwise, the customary ratio was one out of four. Could it be that this proportion of dentists who invariably were absent lacked enthusiasm for dentistry? Were they content to be drifters in the profession?

Obviously it could no longer be attributed to gasoline rationing. Time and distance? No, the location of the sessions varied throughout the year so that the gathering point was a convenience to the practitioners in that particular territory. As for the dentists still remaining in the Armed Forces, theirs was a negligible number. Why, then, was there a meager count of regulars month after month?

An extensive study of the attendance statistics of the district societies throughout the state revealed approximately the same proportion—one quarter to one third—of the members came to meetings regularly.

Platform Voices

Further analysis finally focused on the possibility that the reason was the program speakers. Their platform voices left much to be desired. Not infrequently, they knew what they wanted to say, but because of insufficient preparation, the pressure of time during the presentation, the result from the point of view of audience reaction was a disappointment. Here was a case in point of that reliable motto for every dentist who aspires to influence a group of his colleagues: "An inattentive group means an inefficient speaker."

If speakers should be classified, they would resemble one of the following four types:

1. Those who have something worth while to say, and can speak effectively (orators).

2. Those who have valuable information but a blundering delivery.

3. Those who have nothing to say but can say it well (certain politicians).

4. Those who have nothing to say and know not how to say it.

Give your voice a chance. Not necessarily at the dental meetings, but on the most important platform of all—in your own office. There is your most attentive listener. That patient in your chair appraises your every word, judges you consciously or unconsciously by what you say and how you say it.

What a power is the influential voice! It can instigate revolutions and postpone wars. It sets off strikes or assuages them. It can either muddle the Peace or elevate it to unprecedented levels. And it is the voice which will either confine dentistry or advance it by great strides.

How do you sound to others? Is there room for improvement in your speech? Perhaps you never took stock of your vocal apparatus. You may hesitate to admit that your vocal cords have rolled into a rut. But all voices are capable of modification and improvement; and it is not too late to "stage a comeback," to revive the magic of vocal communication.

Near the top of the list of the dentist's harbored possessions is the feeling that he is a particular individual. He has a mental picture of himself which he wants to keep intact, and is constantly on guard against having his ego destroyed. Consequently, if any changes are to be effected in his speaking traits, those changes must be brought about through the belief that he has made his own decisions and directed his own course of actions.

It may be a ticklish issue to ask your assistant or hygienist for a candid opinion of your voice. That surely calls for courage and tact in their replies. On the other hand, they may have grown accustomed to your mannerisms of speech, whereas a patient hearing you for the first time is likely to wince mentally.

Test Your Voice

If you really want to be convinced, try the voice mirror which the telephone companies sponsor. With this device you can listen as your recorded intonations come right back to you. The reproduction is as true as a snapshot. More than likely you will be reluctant to admit that *that* is how you sound. For, ironically, your voice sounds different to you from the way it does to others. The sound you hear in your head is unlike the tone outside your mouth. Hear yourself as others hear you; half the problem is solved when we bring our shortcomings into the light.

Now you are aware that you have a tendency to mumble words; or that you speak in a nasal, monotonous inflection. Maybe it is a harsh and raspy tone; or a halting, stammering speech. And you never realized until now that your expressions sounded that flat.

Between the extremes of a maundering habit and the near perfection of a radio announcer there is a happy medium. Correctible exercises and a little effort can overcome most distracting characteristics of voice—characteristics which interfere in sustaining the interest of your listener, of winning the admiration of patients.

How to speak with enthusiasm? It is a well-established principle of psychology that if we assume the manner of a given emotion, we shall actually begin to feel the emotion itself.

Speech and the Patient

While what you say may be of import, what you leave unsaid is a foil for talk pertaining to dentistry. It cannot be denied that a certain amount of chitchat and com-

ments on current events are psychological calisthenics for providing the patient with a feeling of relaxation. But constant chatter or purposeless repetition defeats its aim. It is analogous to hearing a piano composition encumbered by too much sustaining pedal. Instead of a pleasantry, it becomes an annoyance.

That patient in the chair is interested primarily in hearing an understandable explanation about his own dental problems. Laconic replies or indirect answers to his questions often lead to suspicion and misinterpretation. The well-exercised voice is the wellspring for clarification. Though the explanation is all there in the corridors of the dentist's mind, it is his vocal organs which virtually open the door of dentistry to his patients. Dentistry has to do with people. By the same token it can be a vitalizing subject for discussion.

Many practitioners, absorbed with ingenious operative techniques, have overlooked the fact that they are treating not teeth *per se*, but human beings. Devoting time and energy to postgraduate courses loses much of its purpose if a dentist refrains from voicing that knowledge to patients in understandable terms. To concentrate only on the patient's oral cavity limits the dentist's horizon. He is not only blindfolding himself to the comprehensive view, but narrowing the future of dentistry. For it is the voice which establishes a closer bond between dentist and patient.

Financial success is largely predicated upon social success and popular approval. A voice which is an asset is an important measure in the achievement of that goal. Dynamic vocal expression is the spur to a self-assured personality.

Yes, your voice is your personal insurance. The more appeal and enthusiasm in your speech, the greater the dividends. Well-modulated tones without irritating hindrances, a pleasing quality of speaking which enlivens patients to react with an affirmative attitude—such a voice is a dentist's most treasured instrument.

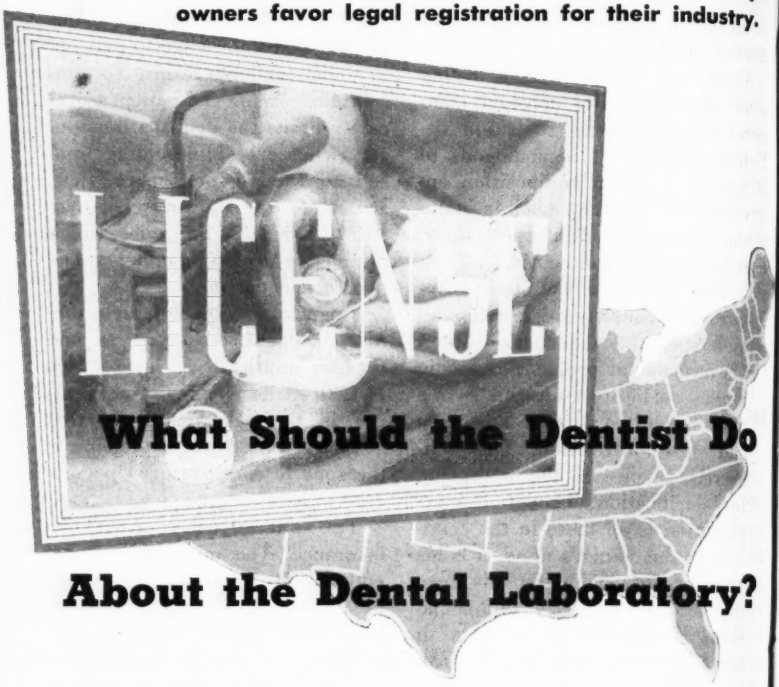
How do you sound to your patients?

28 *Ridley Avenue*
Norwood, Pennsylvania

ORAL HYGIENE AWARD

WINNER OF ORAL HYGIENE'S $100 prize award for the best article published this month is Albert G. Pietsch, D.D.S.

An explanation of why ethical dental laboratory owners favor legal registration for their industry.



What Should the Dentist Do About the Dental Laboratory?

By SAMUEL G. SUPPLEE

ONE OF THE important functions of the Prosthetic Dental Service Committee of the American Dental Association is, in the Committee's own words, "To call attention to the respective responsibilities of the profession and the dental laboratories."

No understanding, by dentists generally, of those responsibilities is possible until all dentists understand the two divergent and disastrous ways in which those relations are now being conducted. When ethical dentists know what is going on, unseen by them, they will surely do something to correct it.

The purpose of this article is not to present anything new but to remind the ethical profession and the ethical laboratories of what has taken place, and to suggest what *may* take place if the two do not adjust their common problems in a *legal* manner.

Forty years ago approximately 95 per cent of the limited number of prosthetic appliances constructed were processed in the offices of dentists. Today 97 per cent of a greatly increased number of res-

torations are processed in the industrial laboratory.

For a number of years the public was unaware of the existence of the industrial laboratory. Today the industrial laboratory is fairly well known. During the intervening period the laboratory industry has developed much along the same lines as dentistry and, generally speaking, is classified under two headings, "Ethical Dental Laboratories" and "Unethical Laboratories."

Laboratory and Patient

On a recent motor trip from coast to coast, we passed through twenty states and visited twenty-nine laboratories. On eight occasions our visit was interrupted by the appearance of a patient who was apparently sent by a dentist to have a repair made, a case checked for bite, or some other adjustment requiring oral service. On two occasions patients appeared to have dentures made direct and were surprised that the laboratory would not perform the service.

The practitioners who send patients to the laboratories provide an excellent opportunity for the unethical laboratories to make "easy" money by serving patients who voluntarily come to them later for new service. This has become embarrassing to the ethical laboratories who have learned that, when they refuse to serve a patient direct, the patient merely searches for an unethical laboratory that will do so. Most ethical laboratories have reached the conclusion that the only protection for themselves and their *clients*, the ethical dentists, is through *legal* means. State societies have sought to correct this growing evil through prescription legislation to little or no avail.

When organized dentistry became aware of the ethical laboratories' demand for legal protection, they apparently misinterpreted the cause; and one society after another chose to bar technicians from instructing members of the profession in prosthetic procedures. Many societies chose to avoid inviting technicians to attend meetings involving the presentation of new techniques.

Technician's Training

Once more organized dentistry forced the ethical laboratories to defensive measures, such as seeking information through second-hand sources. Attempts are being made to establish educational courses for technicians. The unions are making it a part of their programs to establish educational courses for their members to hold them together. The ethical laboratories now employ members of the profession at substantial fees to give classes in advanced technique to their technicians and clients so that they can render a more valuable service. Some state and local dental societies have gone so far as to put resolutions in their minutes mak-

ing it unethical for a dentist to teach fellow dentists prosthetic techniques under the sponsorship of a dental laboratory.

All of these developments apparently have been the result of the FEAR, on the part of organized dentistry, that to permit the laboratory technician to receive important information *within his own field* will lead to some infringement on those exclusive rights the dentists has been entrusted with by the public. This fear is groundless so far as the ethical laboratories are concerned. They seek only protection from the charlatans in their own field and the unethical dentists who seek the services of the unethical laboratories. Were it not for the respect the ethical laboratories hold for their clients, the dentists, they would have sought independent legal protection directly years ago. From a business point of view reputable laboratories today will welcome any kind of legal restriction confining them to strict laboratory procedures.

Accreditation

The problems of the laboratory man cannot be solved by a voluntary method such as "accreditation." Accreditation may appeal to dentists because of their fear, but it will not make the unethical laboratory any better or provide the public with any protection. It only makes it more difficult for the ethical dentist and laboratory to exist, and easier for the unethical laboratory because of its income through illegal practices.

A hundred million dollar industry is now at stake. At present the majority of the laboratories prefer to become legally recognized prosthetic adjuncts to dentistry and to be strictly limited in their field. Business conditions and the influx of new unqualified laboratories may force owners to change their minds and look to state politicians to give them the legal protection dentistry is denying.

Official dentistry seems unaware of what can happen if the public should find out that a large percentage of their restorations are voluntarily turned over by their dentists to irresponsible or untrained technicians (without prescription) to design and construct dentures on their own initiative. Official dentistry *must, for its own protection*, set up educational requirements and schools for technicians, and license those qualified to supervise the production of the laboratories. If dentistry refrains from taking a realistic point of view, and recognizing the technician as an adjunct to the practice of dentistry, it cannot long control the present situation which is growing more acute in many states.

The ethical dental laboratories have sought to make an honorable living by serving the profession with better dentures. They have realized that this could only be accomplished by knowing more about the needs of the profession

and the functioning of the dentures they processed. The unethical laboratory is primarily interested in processing dentures at a *price* regardless of value to the dentist or the public.

Technician's Responsibility

As time has passed, dentists have learned to lean more and more on the technician *regardless of his ethics;* provided, however, that when a denture could not be worn by the patient, the technician would be obliged to make it over *without charge.* The more dentists came to lean on the laboratory and demand acceptance of responsibility, the more careless they have become in their technique by way of errors of omission and commission. This has resulted in more frequent remakes.

Ethical laboratories, in their struggle for existence, soon became aware that one remake without charge cost them more than the profit on three to six new dentures and made it unprofitable to work for many of their clients. Interchange of information between laboratories disclosed that most of them were having the same experience.

A number of years ago laboratories made a study of the causes of remakes in the form of errors of omission and commission. They then began to instruct their clients, the dentists, individually and collectively, on how to make preparations and take impressions to insure against remakes. This was at first favorably received by the profession who soon began sending patients to the laboratory the laboratories for impressions or denture adjustments. Since repairs were unprofitable, many preferred to send their patients directly to the laboratory.

Shades and moulds are usually a controversial matter and dentists soon adopted the custom of sending patients to the laboratory to make it responsible. In a comparatively few years, the public became more and more aware of the part the laboratory was playing in the practice of dentistry. The ethical dental laboratories, being unable to charge for these services, have sought to avoid them. Many dentists now patronize only laboratories that will render services to their patients.

I do not want to imply that all ethical dental laboratory men are above reproach, but I do maintain that they want to conduct their business openly and above board and work for, and not against, the dental profession. If given legal protection within their own field, dentistry will benefit more than the laboratories or the technicians.

Public Service

It might be well for dentists and technicians alike to read carefully a paper by R. W. Bunting, D.D.S., Dean, School of Dentistry, University of Michigan, published in the January, 1946 issue of the *Laboratory Review.* Doctor Bunt-

ing points out clearly the needs of the dentist, the laboratory, the technician, and the public:

"The dental laboratory should have full recognition and credit for the part it plays in dental health service. It should have a well-defined status and some means should be provided to correct evils of the laboratory-dentist practice. The laboratory should not be at the mercy of the unfair dental practitioner, and the dentist should not be at the mercy of the unscrupulous laboratory.

"In the development of any project, the objectives should always be borne in mind. The objective of laboratory-dentist relationship is, in the last analysis, *service to the public.* If the dentist fails to use the laboratory or the laboratory fails in its service to the dentist, *it is the public who suffers most.*"

Several state dental societies have recognized the need of a legal approach to the education and registration of the laboratory and technician. Until recently, all efforts by states along this line have been suppressed by the national organization on the basis that the solution lay in "accreditation" which is the modern name for "certification." Certification was condemned by most laboratories and many dentists years ago as a liability to the ethical laboratory and an asset to the unethical laboratory.

Fortunately the setup for accreditation recognized *state rights,* and the laboratories should be grateful to New York State Dental Society for being the first to declare its belief in *legal* rather than voluntary control of a situation it now recognizes as acute. It is to be regretted, however, that the society wishes to avoid the education of the technician at this time. Second honors should go to the State of Texas, which has gone on record as opposed to "accreditation," followed closely by the State of Pennsylvania.

A standard for the education of technicians in recognized schools should be set up as soon as possible, under the jurisdiction of official dentistry. Qualified ethical technicians can be helpful in a matter of this kind if their cooperation is invited. Qualified technicians should be duly registered or licensed to supervise the construction of dentures in the industrial laboratory as a protection to dentistry and the public.

17-19 *Union Square*
New York City

EDITOR'S NOTE: Since this article was prepared, the author has attended an official meeting of the Prosthetic Dental Service Committee of the American Dental Association held in New York.

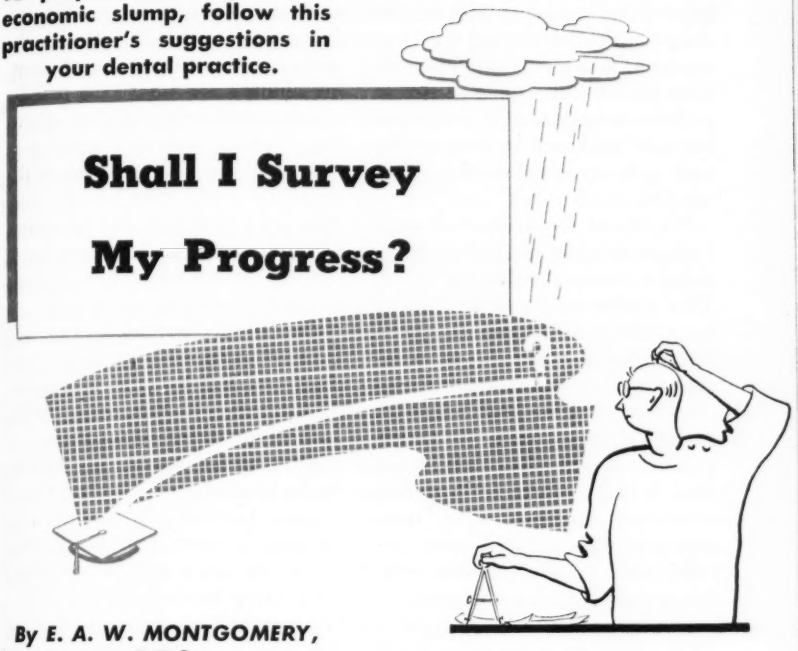
The several representative laboratory men invited to attend learned that the task of organizing the Accreditation Plan has been completed by the National Committee. Any further activities relative to the operation of this plan will rest entirely with the Prosthetic Dental Service Committee of each State to discuss their problems with the State Laboratory Associations. It will be their duty to determine the value of accreditation.

Members of the laboratory industry may be assured that, regardless of their appraisal of the value of accreditation, one of the main objectives of the National Prosthetic Dental Service Committee will be to continue to seek a mutually satisfactory solution to the problems facing both dentists and laboratories.

The Committee will soon release an outline of a plan for the next step in their effort to establish better dentist-laboratory relations.

To prepare for a probable economic slump, follow this practitioner's suggestions in your dental practice.

Shall I Survey My Progress?



By E. A. W. MONTGOMERY, D.D.S.

DURING WORLD War I, I was a sailor aboard the *U.S.S. Topeka.* One fine summer day we pulled into Key West, Florida, to coal our ship. After the day's work was finished, we sailors were permitted to go swimming near our ship. Being a good swimmer, I leisurely rolled over on my back and floated around. After about ten or fifteen minutes of this leisurely floating I found that the tide had carried me out to sea. If the tide was swift enough to carry me out this fast, I realized it would take some effort to get back. There was no use calling for help for no one could hear me. So I said to myself, "Do not lose your head, but go to work." The task was most difficult, and I am sure I am alive today because as I swam I was able to survey my progress by the rows of piling off in the distance. This was my only means of determining if I was gaining on the tide that was trying to carry me out.

You will say, "This is a good story, but what has it to do with dentistry?"

Many dentists are floating out to sea in a leisurely manner. Patients are plentiful, most patients

have enough money to pay the dentist without surveying the value received, and many dentists, with their pockets full of money, are so gullible as to think that the public has just awakened to their ability and will always beg for their services.

You know the kind of dentists I am talking about when I say there are many floating out to sea. They are the kind who are "riding for a fall," the kind who have overlooked the sound business principles that are necessary for continued success, the kind who have developed the arrogant, "mightier-than-thou" attitude. They think they do not need to further their education, improve their technique, or assume their responsibility as a member of their profession and dental association.

Your Ability

If you fall into any of the foregoing categories, then you should roll over, survey your surroundings, and see what can be done about it, before the tide carries you too far.

You will note that I said "I was a good swimmer." That means I had the ability which is a prime requisite. If you want to retain this favored, successful position, then make a fair survey of your ability. Judge yourself on this basis: Can I perform dentistry as well as the best; if not, how can I improve myself? Is my office as attractive as the offices of other successful dentists, or should I do some remodeling? Is my office as efficient as it could be? Do I have proper equipment to supplement my ability? Do I have the proper supplemental help? If these questions can be answered satisfactorily, then you have the tools with which to work. Your ability plus these tools will help you to maintain the successful level you have reached, or to recover lost ground if you have drifted out to sea.

One of the hardest things for most of us to do is to admit our shortcomings, but the successful dentist must do this periodically and do something about them.

Most of the dentists are riding on the crest of an inflated economic wave, but this inflated wave will collapse. It is my hope that it will not let us down any further than the average level of 1936 to 1939, but it could be worse. You dentists who were established in the 1936 to 1939 period can remember that conditions were much different then. The successful dentists and the dentists with pockets full of money were few. Remember this, you will return to the 1936 to 1939 level unless you do something to prevent it.

Socialized Dentistry

Not only do we have to consider the economic conditions as a general trend to dislodge us from our favored position, but there is a small organized minority group that has created a tide which is trying to dislodge us from our favored position and carry all of us

out to sea. This tide of socialized dentistry must be dealt with in an organized fashion if we are to survive. It is only through strong support on our part that the efforts of the minority groups that are trying to socialize us can be effectively combated.

I do not want to be classed as an alarmist unless I can be classed with those who are trying to prevent both the economic conditions and socialized dentistry from carrying us out to sea.

Let us not fool ourselves as dentists because of the great number of patients we are serving or the inflated income we are receiving. This condition is not because of any effort on our part but strictly the result of economic conditions and lack of civilian dentists.

The wise dentist will plan ways of continuing to serve a large practice; thereby enjoying a larger income. The following are a few suggestions that may be beneficial:

1. Attend and take an active part in the clinics of your association. See if your technique can be improved, and be willing to show others if you think your technique is right.

2. Look over your office and see if you are proud of your daytime home. If a few of the patients do not compliment you on it, then it is a disgrace to you and the profession. See if a little added color, a new piece of equipment, or some cheerful pictures, may not be all that is needed to add to its attractiveness.

3. Let us be more considerate of our patients. There are many people who are carrying a little black book and who say they are going to "get even" with those whose names are in the book for the way they have been treated during the war. A good standard to follow with regard to public relations is to ask yourself these questions: "Is the way I am treating this patient the way I should like to be treated if I were going to a dental office?" "Is what I am doing for this patient what I should want to have done for me if I were in his place?"

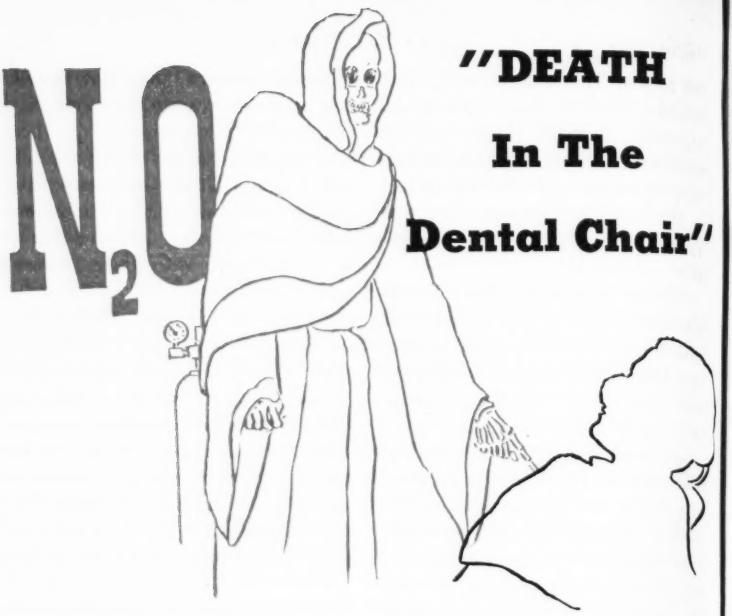
4. See that all supplemental help carries out the policies of the office. See that enough supplemental help is employed to make the office operate at top efficiency.

5. See that your personal appearance and public relations are a credit to you and your profession.

If you will analyze carefully these five suggestions, and will do what you can to put them into effect, then I am sure you can retain that favored position you now hold. With ability, conscientious effort, sound business principles, and concentrated energy, you will be a successful dentist.

1006 *Hulman Building*
Evansville, Indiana

N_2O "DEATH In The Dental Chair"



Is more stringent legislation necessary for the dentist in his use of nitrous oxide-oxygen anesthesia?

By LOUIS WILLINGER, D.D.S.

MUCH HAS been published recently in the daily papers relative to fatalities in the use of nitrous oxide-oxygen by members of the dental profession. It is certainly tragic when a patient dies during the administration of any anesthetic. It is also tragic when a patient dies from a heart attack or any other cause in a dental office. Patients also die on hospital operating tables for one reason or another. Nothing much is ever said of this. A death certificate is signed, the incident closed and charged up to the hazards of surgery. The public is not given information which tends to demoralize and frighten it. Neither are the involved members of the medical profession taken to task or publicly reprimanded. When a death occurs in a dental office, however, it is an occasion for wide, irresponsible publicity to the detriment of all concerned.

While sudden deaths occur in bed, on the street, on the golf course, and in diverse other places, the dentist knows well that a death in his office during anesthesia

makes front-page news. In this way a great personal wrong is done and the public is given an erroneous conception of the methods which dentists have at their disposal for making their service as painless as possible. Only too frequently thoughtless or irresponsible members of the health professions make remarks which border on the unethical in reference to these accidents during anesthesia. If any comment at all is necessary, it is best to share responsibility and lighten the burden of the involved dentist by simply saying, "It might have happened to me."

The successful use of nitrous oxide-oxygen over a period of many years has convinced me that the adverse criticism which it is receiving in the lay press and from certain members of the medical and dental professions is without foundation, and thereby constitutes a distinct disservice to the advancement of dental anesthesia.

It is not my purpose at this time to go into the physical and chemical properties of these gases, or the technique involved in their use. I wish, rather, to decry and, if possible, controvert some of the current unfavorable publicity, which the administration of nitrous oxide-oxygen by the dentist is now receiving. I also desire to give some reasons why the clamor by some newspapers and their political stooges for more stringent legislation for the dentist in his practice of general anesthesia is unjustifiable and discriminatory.

It should be borne in mind that nitrous oxide-oxygen is the safest of all general anesthetics, though perhaps not the easiest to administer. It is non-irritating and is not injurious to any vital organs. As it is breathed in, so is it eliminated from the body. The pleasant induction, rapid loss of consciousness, flexibility of control, comparative freedom from vomiting and salivation, speedy recovery and lack of complications, have given it a just popularity for minor operations and for many major procedures as well.

It should be known that in hospitals patients who require a general anesthetic are first given nitrous oxide-oxygen and then ether, or some other type of anesthetic is substituted if prolonged anesthesia is required. This is the accepted procedure by most anesthetists. The reason thereof may perhaps be attributed to the greater skill and care required in the use of nitrous oxide-oxygen for prolonged anesthesia. In the majority of hospitals the anesthetic of choice continues to be nitrous oxide-oxygen alone or in combination with other gases.

Better Training Needed

It is not for politicians or publicity mongers to decide upon the qualifications a dentist should possess for the use of nitrous oxide-oxygen anesthesia. I, for one, am for improving the ability of the dental practitioner in the use of this excellent humanitarian agent.

In my opinion this is definitely a problem for our colleges, hospitals, dental state boards, dental societies, and teachers of general anesthesia. Instituting legislation to prevent or hinder a dentist from using nitrous oxide-oxygen would be the equivalent of passing legislation to prevent a dentist from extracting teeth or performing the many other operations within the scope of his practice.

It is my opinion that the majority of dentists who use nitrous oxide-oxygen have acquired the necessary knowledge and skill for its administration. It is only the foolhardy practitioner who administers these gases without being fully qualified. Taking into consideration the tremendous number of nitrous oxide-oxygen administrations per year in dental offices throughout the country, the percentage of fatalities can be considered as negligible. The wonder is not that they do occur but that they are not more numerous. When all the evidence is in and when due consideration is given to the diverse conditions under which these gases are administered, it must be admitted that this form of anesthesia *per se* as a cause of death is, relatively speaking, rare. This fact must not lead to carelessness, but rather it should encourage those engaged in the use of nitrous oxide-oxygen anesthesia to be on their guard and to improve constantly on their knowledge and technique. Again, I wish to emphasize that it behooves the dental profession to make certain that all dental practitioners who administer anesthetics of whatever nature have the necessary qualifications. I am, however, definitely against any legislation which would prevent or in any way hinder dentists in the use of any well-tested, accepted anesthetic agent.

It may not be amiss for me to state that whenever a fatality does occur during nitrous oxide-oxygen anesthesia, it is usually the result of the maladministration of the anesthetic. The nitrous oxide-oxygen has been pushed to extremes without sufficient oxygen; thus bringing about a condition simulating asphyxia, strangulation, or carbon monoxide poisoning. The oxygen of the blood cells to a great extent has been displaced. This dangerous state, anoxia, may result in severe symptoms which may prove irreversible. Nitrous oxide with oxygen in correct balance while capable of bringing about a state of hypoxia (slight lack of oxygen) is not likely to cause personality changes or cerebral cortical damage. An improper position of the mandible or the head may obstruct the upper respiratory tract and produce asphyxia. A balanced mixture of nitrous oxide-oxygen administered intelligently will not endanger life or damage the nervous system. It should be understood, however, that the risk cannot be completely eliminated from any operative procedure.

355 *East* 149*th Street*
New York 55

So You Know Something About Dentistry!

QUIZ XXIII

1. What is traumatic occlusion? .....
2. What structures pass through the posterior palatine foramina? ....
3. Which of these is a refrigerant local anesthetic? (a) monocaine hydrochloride, (b) procaine hydrochloride, (c) ethyl chloride, (d) tutocaine hydrochloride. .....
4. What does hot work as applied to metals and alloys mean? .....
5. A casting ring is lined with asbestos to (a) absorb excess water in the investment, (b) allow investment setting expansion to take place, (c) protect the ring during casting. .....
6. The fulcrum of a tooth in function is located (a) near the gingival line, (b) near the apical foramen, (c) apically from the middle portion of the root. .....
7. Recommended porcelain for the complete veneer porcelain crown is (a) low fusing, (b) high fusing, (c) medium fusing. .....
8. The mesiodistal width of the deciduous molars is (a) narrower than, (b) the same as, (c) greater than, the mesiodistal width of the succeeding bicuspids. .....
9. What per cent of first permanent molars are lost before 12 years of age? (a) 9 per cent, (b) 2 per cent, (c) 25 per cent. .....
10. In taking roentgenograms of the teeth, the tube is placed so that the central rays will be directed at the (a) incisal or occlusal portion, (b) apex of the root, (c) gingival line of the tooth. .....

FOR CORRECT ANSWERS SEE PAGE 1392

Doctor Balint Orban (extreme left) examines the patient's roentgenograms before demonstrating a surgical gingivectomy to a class of veteran dental officers. Doctor Isaac Schour, Associate Dean in Charge of Postgraduate Studies, is shown in the center holding a notebook.

Long-Range Postgraduate Program Initiated by University of Illinois

Progressive dental education courses will be given to veteran dental officers by an outstanding faculty under the direction of the University of Illinois College of Dentistry.

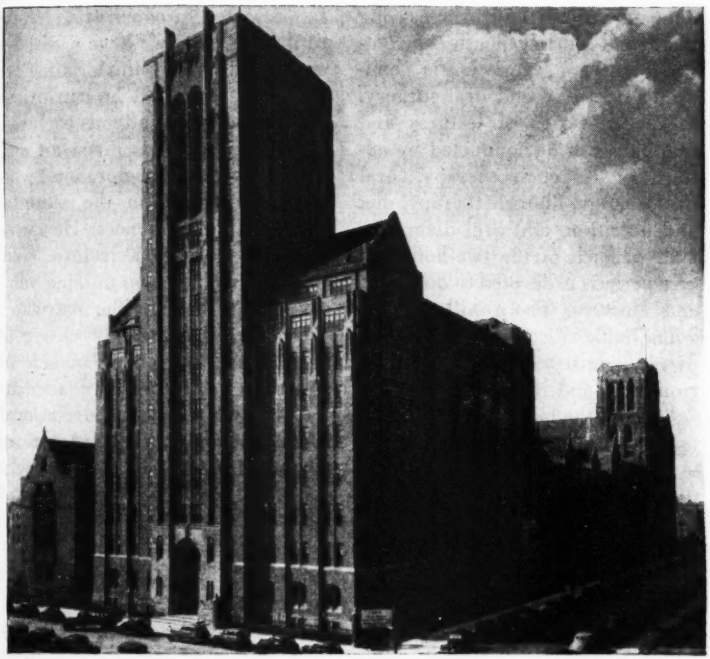
AN EXPERIMENT in a new type of postgraduate training for veterans and civilian dentists is now underway at the University of Illinois College of Dentistry under the direction of Doctor Isaac Schour, Associate Dean in charge of the Postgraduate Program. The first of a series of twelve-week courses designed to give intensive training in the entire field of dentistry has been completed, the second begins on September 9 with an enrollment of thirty-six students, and the third will start January 6, 1947.

The unusual feature of this postgraduate program is that the University of Illinois has called on outstanding dentists outside

its own faculty to assist in giving the courses. Doctor Schour has also arranged for lectures by specialists in public health, otolaryngology, hematology, and other related fields. The postgraduate students are also invited to attend general University lectures given on the Chicago campus of the University of Illinois.

To finance this ambitious program the University is not depending on government funds. Although the tuition and maintenance of the dental officers will be paid under the G. I. Bill of Rights, a grant of $50,000 from the W. K. Kellogg Foundation will be used to pay the costs of instruction. This grant will extend over a period of three years after which time the University intends to continue the program with its own funds developing it as a permanent aid to practicing dentists.

In discussing the program Doctor Schour said, "At the outset the courses were organized with special emphasis on the requirements of returning veterans who wish to



University of Illinois College of Dentistry, Chicago, where the postgraduate courses are given.

obtain a short but intensive training in the principal fields of dentistry including the latest clinical and therapeutic advances. Those dental officers whose undergraduate training was shortened because of the accelerated wartime schedule will have an opportunity in these courses to fill in the gaps and prepare themselves to take advanced training in special clinical fields."

Instruction will be rotated through the clinical fields so that the curriculum will include didactic and clinical courses in operative dentistry, crown and bridge, complete and partial dentures, root-canal therapy, periodontia, children's dentistry and oral surgery. A special series of lectures and seminars will be conducted by authorities in chemotherapy, oral bacteriology, fluoride therapy, diet and nutrition, and oral diagnosis. Half of each of the two-hour lecture periods is devoted to questions and answers. There will also be round-table discussions on children's dentistry, oral surgery, periodontia, and related subjects.

"One of the reasons that we hope to make our postgraduate program a real and a permanent contribution to adult professional education," Doctor Schour pointed out, "is the fact that we are broadening the base of instruction in every way possible. By seeking talent outside of the University we are trying to assemble a faculty with the widest possible interests and information. Among the faculty members we have Doctor George Hollenback, who has participated in the instruction on crown and bridge, and operative dentistry; Doctor F. E. Roach, an authority on partial dentures; Doctor Balint Orban, leading periodontist and investigator of the Loyola University dental school; and Doctor Wilton Krogman, anthropologist of the University of Chicago, who will lecture on the importance of the teeth and jaws in crime detection.

"As these lectures are in specialized fields and must necessarily be presented in concentrated form to the students, we have devised a system of saving valuable time for the dentist. So that he can orient himself before he attends each session, the student is given an outline of the lecture beforehand with questions based on the material and reading references. He never needs to go into a lecture 'cold' and take a chance on missing valuable points made by the instructor. To bring the students closer to sources of information outside of our own institution, we also arrange field trips to the National Headquarters of the American Dental Association and to the Northwestern University Dental School Library."

As to future plans, Doctor Schour said, "During the next three years we expect the needs of the veterans to be satisfied. We will then continue these courses as our contribution to adult postgraduate education, and we expect

that students will return every three or four years to take the course again. It is our purpose to concentrate on this program and not to give short courses in duplication of those given in other dental schools."

Veterans enrolling in this course will find that their tuition requirements are taken care of under the G. I. Bill of Rights. If they are on terminal leave or already separated from the Service, however, they must present their "Certificates of Eligibility and Entitlement" from the Veterans Administration when they register. For detailed information, all inquiries should be directed to Doctor Isaac Schour, Associate Dean in Charge of Postgraduate Studies, University of Illinois College of Dentistry, 808 South Wood Street, Chicago 12.

DENTAL LIFE REFLECTED IN PRIZE-WINNING STORIES

ALMOST $4000 in awards have been won by dental writers in the monthly ORAL HYGIENE contest in which the author submitting the best story published each month receives a $100 prize.

Dental officers, civilian dentists, dental assistants, and dental hygienists, have been awarded prizes for a wide variety of stories. "The Dentist Has a Housing Problem Too" is the title of one prize-winning article and another one answers the timely question, "Who Will Get the Surplus Dental Property?" One dentist described his rugged life on the Yukon, another offered his reasons for the failures in dentistry.

Your own story may be just as interesting as any of those you have read in ORAL HYGIENE. And you are the only one who can tell it!

If you don't have a gift for feature writing you may have practical suggestions for improving dental practice, for the wider distribution of dental service to the public, for a retirement program, or a plan to aid dentists who are returning from military service.

Whatever your ideas about the future of dentistry are, we want to know about them. Tell us in 1500 words what your own plans are or what the dentists around you are thinking and talking about. Here are the rules to follow:

1. Your article must have a dental angle.
2. Set down your ideas in simple, direct, forceful language without literary flourishes.
3. All manuscripts must be limited to 1500 words, typed, double-spaced, and accompanied by return postage.

Send your story now! You may be the winner of the next $100 award. Mail your manuscript to: Edward J. Ryan, D.D.S., Editor, ORAL HYGIENE, 708 Church Street, Evanston, Illinois.

Dentists in the News

New York (New York) Times: Doctor David Reese, Dayton, Ohio, dentist, has been elected Commissioner of the new Mid-America Athletic Conference. Conference competition will begin with the 1946-1947 basketball season. Doctor Reese expects to announce the basketball schedule and the 1947 football schedule for the Conference in the near future. Present members are the University of Cincinnati; Butler University of Indianapolis; Ohio University of Athens; Wayne University of Detroit; and Western Reserve University of Cleveland.

The 53-year-old dentist has been basketball and football official of Western Conference for many years. He reports that he expects to referee a full schedule of Western Conference football games this fall and then retire from officiating.

Bronx (New York) Home News: A converted garage is Doctor Milton H. Bonart's solution for the present shortage of dental office space. Upon his re-

turn from Army Dental Corps service, this Bronx dentist spent almost a year making a futile search for office space. The few homes for sale were either in unsuitable locations or were being held for exorbitant prices.

While looking through the neighborhood in which he practiced before the war, Doctor Bonart discovered the garage. The landlord was sympathetic with the dentist's plight, and arrangements were made to convert the building. The former garage was transformed into an attractively decorated waiting room, two operating rooms, a laboratory, and a darkroom.

Few of Doctor Bonart's patients are aware that the office where they receive dental treatment was recently a four-car garage. Looking around his office with satisfaction, Doctor Bonart related: "I had one visitor who gazed open-mouthed at the spot where the dental chair stands and then exclaimed: 'Why, that's where I used to park my Chevvy.'"

Chicago (Illinois) Daily News: The quick action of a dentist saved the life of a 12-year-old caddy at the Elks Country Club, Paris, Illinois, recently. When golfers were clamoring for hot water in order to take their showers, Charles Matheny fed a smouldering coal fire a cup of coal oil. As a result his clothing caught on fire. When Doctor N. M. Sullivan, Paris dentist, heard the boy's cries, he rolled the caddy in the grass and tore the burning clothing from his body. The dentist was so severely burned about the hands and arms that he will be unable to practice for some time.

Kansas City (Missouri) Times: Doctor Elmer G. Kesling, Bloomfield, Missouri, dentist, has been awarded a judgment against the Chevrolet Division of General Motors Corporation for $310,468.08 for patent infringement. The patent was for a vacuum booster mechanism for shifting automobile gears which, by admission of their counsel, the General Motors Corporation used 2,034,400 times. The award was at the rate of 12 cents for each time the booster was used.

Muskegon (Michigan) Chronicle: Arrangements for the construction of a new bungalow dental office have been completed by Doctors J. C. and J. H. Nolen, Muskegon dentists. The building will be erected at Peck Street and Grand Avenue at an estimated original investment of $25,000. It is expected that the total cost will reach $400,000.

Chicago (Illinois) Sun: Doctor William Treutle recently furnished one of his patients with more than dental treatment. Sixteen-year-old Michael Stuart, who came to this country from China as a stowaway and was being held in San Francisco for deportation, was taken to the Marine Hospital with a toothache. Doctor Treutle, who relieved the toothache, was so impressed with the young boy that he posted bond with immigration authorities for his release.

Michael was born in Hong Kong of British and Portuguese parents, and orphaned at 9. He lived in China throughout the war and managed to get into this country three months ago. The dentist and his wife, who have no children, plan to take Michael with them when they return to their home in Tacoma, Washington.

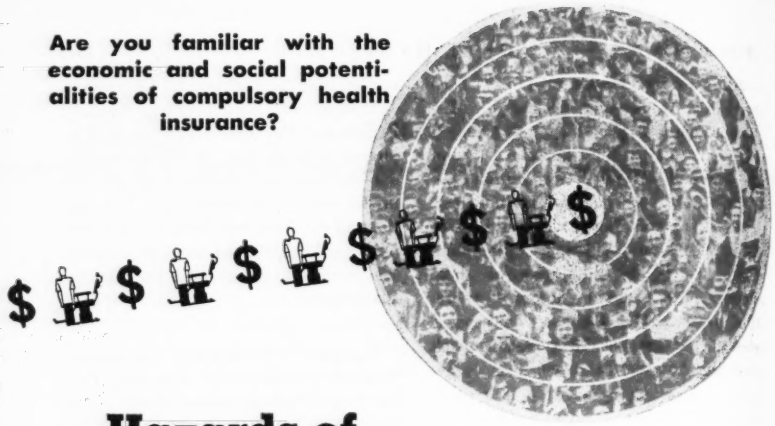
Nashville (Tennessee) Tennessean: Nashville's hole-in-one champion, Doctor J. H. Phillips, whose dental offices are in the Medical Arts Building, was the oldest golfer competing in the opening day of the annual City Senior Tournament at the Belle Meade Club. He is 75, and, despite blazing summer heat, came in with a score of 88. This dentist has shot six holes in one during his long career on the golf links.

New York (New York) Daily News: Doctor David B. Ast, Chief of the State Health Department's Dental Bureau in Albany, left recently for Europe where he will aid in dental rehabilitation of displaced persons under the direction of the American Jewish Joint Distribution Committee. In 1944 Doctor Ast started the experiment in the Newburgh-Kingston area of treating drinking water with fluorine to prevent dental caries. He will be on leave of absence from the State Health Department.

This month's awards for stories published in DENTISTS IN THE NEWS have been won by:

MELVIN KATZ, D.D.S., 4808 Bergenline Avenue, Union City, New Jersey.
F. H. GINSBURG, D.D.S., 1180 Gerard Avenue, Bronx 52, New York.
S. J. HLETKO, D.D.S., 1943 West 48th Street, Chicago 9.
MRS. JOHN W. RICHMOND, 5241 Mission Woods Road, Kansas City, Kansas.
HARRY L. SPOONER, 1033 Antoinette, Peoria 6, Illinois.
JOHNSON G. MCDOWELL, D.D.S., 626 Doctors' Building, Nashville 3, Tennessee.
MRS. J. E. PUTRIN, 24-37 24th Street, Long Island City 2, New York.

Are you familiar with the economic and social potentialities of compulsory health insurance?



Hazards of Compulsory Health Insurance*

By ELIZABETH W. WILSON

PROPONENTS OF compulsory health insurance in the United States have contrived to keep the debate on the level of humanitarianism, where it is not too difficult to prove that some Americans who get no medical attention these days would get some under their scheme.

Thus, opposition to the Wagner-Murray-Dingell Bill has been left largely to the medical profession, which argues, chiefly, that it can provide health services better and cheaper by itself than with the government at its elbow.

This is the shirking of a plain duty by the business community. Business and industry, in the long run, must provide a rising standard of living for the country. Business and industry should examine compulsory health insurance not alone for the desirability of its professed goals—no one quarrels with those—but also as to the ultimate cost and the braking effect that cost will have on every activity of the Nation.

The Wagner - Murray - Dingell Bill, if passed, will make this country the forty-second to promise workers and their dependents medical care and cash indemnities for wage losses resulting from illness. Experience in these other countries offers us some clues as to whether the Nation's payrolls can bear this

*Reprinted with permission from *Barron's National Business and Financial Weekly*, April 8, 1946.

load in addition to payments for old-age benefits and unemployment compensation.

Costs

The size of the burden of compulsory health insurance costs and its relation to kindred burdens already being borne are consistently underestimated by the Wagner-Murray-Dingell Bill's proponents.

President Truman has said that from the outset the medical benefits of the bill will cost about $325 billion a year, or 4 per cent of payrolls. Experts say this is optimistic; that the initial cost will be nearer $4 billion a year than $3 billion.

On top of that 4 per cent, cash benefits will start out by costing almost 2 per cent of the national payroll. That is also on top of the 2 per cent now going into old-age and survivorship benefits, and the 1.8 per cent on an average that is paid for unemployment compensation.

Many competent observers say that even this 9.8 per cent-of-payroll figure is too small to start with, and there is no room for doubt that it will soon be far above this total.

First, medical costs will increase. "Adequate medical treatment" is becoming a more and more expansive and expensive term. Laboratory analyses, roentgenograms, and the services of specialists, are costly. More expensive drugs are prescribed oftener.

Proponents of health insurance contend that employers will be reimbursed for their increased tax payments by a rise in productivity of their presumably healthier employees. The fact is that the claim rate continues to rise every year. Assuming that a certain rise in early years would be the result of the fact that sick persons, who nowadays continue to work because they have to bear the whole burden of laying off, would feel they could afford to stop work and take treatments, the load should flatten out after awhile.

If it does not—and it has not in any other country—either national health is not improving as promised, or else malingering is not being controlled firmly enough.

Cash benefit costs will increase with medical costs. In England, the claim rate for wage-loss benefits increased 50 per cent in six years. In Germany it trebled between 1885 and 1930. In England a survey in 1938 showed that 15 per cent of those receiving cash benefits were "not unable to work."

Malingering will be worse in this country than in England, because here it is planned to operate the whole plan by a federalized bureaucracy, whereas the Approved Societies, which are cooperative groups of workers, manage the British benefits. Workers obviously are better placed to combat malingering than are agents of a democratic government.

Payroll Load

In the light of these considerations, it appears probable that health insurance would cost more

than 8 per cent—some say 10 per cent—of the payroll of insured workers during the next ten or fifteen years. That would be a load of $7 billion by 1960. This estimate is reinforced by the 300 per cent rise in per capita costs of health insurance in Germany from 1914 to 1929, and the 250 per cent increase in Britain in the same period. Worse yet, actuaries estimate that the increase in costs will not flatten out for fifty years.

Unemployment compensation costs can be expected to rise, too. The current 1.8 per cent rate applies in a period of high employment. Considering the constant pressure for more liberal benefits, and the probable level of peacetime unemployment, it is highly optimistic to set the future annual level premium cost of unemployment insurance at as little as 2 per cent after the reserves accumulated during the war are paid out.

Old-age and survivorship benefits have cost less than was expected during the war. Many old people returned to work; they will retire again and draw their benefits. Moreover, there is a move afoot to liberalize the benefits. Actuaries estimate that under all reasonable assumptions old-age and survivorship benefits will cost at least 4 per cent of the payroll sometime before 1960.

Although there is a reserve for this type of insurance, it is much smaller than was originally contemplated, because Congress continues to defer the increase in taxes which would build the reserve to its projected size. This means that in a few years the whole social security bill will have to be paid on a current-cost basis.

During the next ten or fifteen years, the total annual cost of social insurance will be somewhere between one seventh and one sixth of the payroll, or $10 to $12 billion. It is almost certain that before the costs are stabilized, they will equal or exceed those of the British system which are estimated at 24 per cent of the wage bill.

General Taxpayer

It would be inexpedient to have the worker and employer bear this whole cost. The May, 1945 edition of the Wagner-Murray-Dingell Bill provided that the employer and employee should each be taxed 4 per cent of the payroll. Thus, from the outset, a large and increasing sum would have to be defrayed by the general taxpayer. Already he has to meet the costs of the federal and state governments, as well as interest on the public debt, a burden which will probably not fall below $30 billion a year for many years to come.

Besides supporting the various governments and paying their debts, the general taxpayer—either as an individual or a corporation—is the source of funds on which business draws for expansion and research necessary for increased productivity. The crux of the economic problem of health insurance is this:

"Can business expand and become more productive if the funds of the general taxpayer are curtailed by taxes to meet an increasingly heavy social security burden on top of his other commitments?"

Political dangers in the health insurance program offered this country are just as real as the economic ones, although less obtrusive. The bureaucracy necessary to administer the Wagner-Murray-Dingell Bill might comprise 500,000 persons or more. These government agents would be strategically placed in every village and in every district of every sizable city.

We may credit American voters with enough political maturity that the danger of such a machine being seized by a demagogue, as Hitler seized its corresponding facilities in Germany and turned them to his own uses, is remote. But we have seen our farm aid machinery, in its limited field, turned to producing majorities in referenda on farm-control policies that Hitler might have regarded with envy.

There is no guaranty that the health insurance bureaucracy would not groom a class of benefit-receivers as compact and as single-minded for their own interests as the farmers are for theirs.

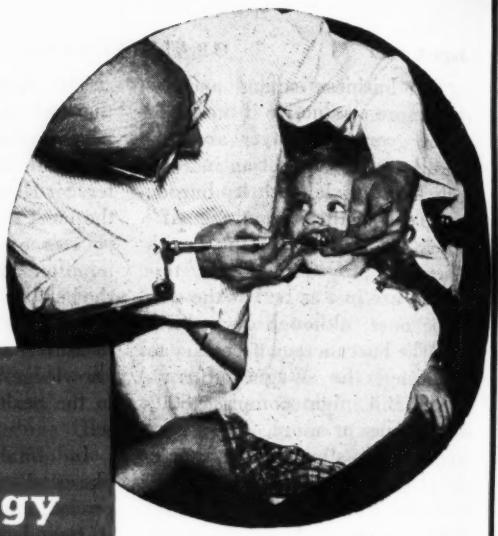
Health Effects

Aside from the tremendous cost and the grave political dangers, there is the major consideration that the health insurance probably will not have even the beneficial effects claimed for it.

This doubt is not based only on the fact that the rate of claims never levels off, as it should if public health were really growing better. Sir Henry Brackenbury, one of the most distinguished British advocates of health insurance, has admitted that any betterment in the health of the people may be because of "education, public health measures, and increase in medical knowledge," and not attributable to the health insurance system itself.

Indubitably, there are some places where public health has improved, and there are some where it has deteriorated. An English publication, *Labor - Management*, admits that the medical services under health insurance, have developed "with patches of brilliancy, and patches of gross inefficiency." It is not primarily the fault of the insurance physicians; they are overworked. One writer estimates that, even before the war, the average consultation with a panel physician lasted only four minutes.

It is not surprising that the workers distrusted this type of medicine. The facts are these: In 1936, about 600,000 British workers renounced their right to medical care under the insurance system by failing to register on the panel. In the same year, one third of the French workers who were eligible for insurance did not qualify for it. These facts underscore the question as to the medical success of health insurance.



Before attempting to use the drill, I always place a rubber cup in the handpiece and administer it to the tooth to be restored.

Child Psychology That Pays*

By STEWART A. MacGREGOR, D.D.S.

This dentist's suggestions may aid you in your treatment of the child-patient.

THIS TITLE "Child Psychology That Pays," might be interpreted in two ways. First, in managing a child in the dental office, one must use an approach that will pay dividends by suggesting to the child that the dentist is at all times in full command of any situation that might arise. Second, one must use an approach that will allow you to make a living.

Considerable material has been written about child management in the dental office, and much of our literature, I am afraid, has frightened the general practitioner rather than helped him. A playful time-taking approach generally has been recommended. We are told to get down to the child's level, take him by the hand, show him the laboratory, show him the lathe, show him the sterilizer, and, in fact, everything about the office but the bookkeeping system. Some suggest playrooms and others offer bribes, such as plaster models, clubs, and other rewards. All this has a tendency to make the general practitioner feel that if he has to do this to make a living then he will do prosthetics and "let George" do the children's treatment. For a number of years in my practice I followed such procedures, and, although I met with fair success, it was extremely diffi-

*Adapted from the *Journal of Dentistry for Children*, Second Quarter, 1946.

cult because of the nervous tension. As I look back now, I feel that the child was in control most of the time and, from an economic point of view, treatment of children was a failure because of the additional time spent on it.

After fifteen years of practicing for children, it is my belief that, if you ask a child to look up to you and respect you on the first appointment, rather than lower yourself to his level, your chances of success will be greater. I do not wish to be misunderstood by this statement; I do get down to their level in a playful manner, but only after I have succeeded in impressing them that I am in command of any incidents that may arise in the office. It also has been my experience that when I took the child on a tour of the office, he frequently became so familiar with this new environment that he felt he had greater privileges. Not only is this method impractical from the psychologic point of view, but it is impossible economically.

I asked a kindergarten teacher once what she did when a child, accompanied by the mother, came to school for the first time but refused to stay. She replied, "But we expect him to stay." That sums up my attitude toward the child on the first dental appointment. I take an "expect-him-to-behave" attitude, and he soon senses it no matter how young he may be.

First Appointments

My approach to a small child on a first dental appointment is as follows: While the dental assistant is preparing the operating room, I make it my business to open the reception room door, say "Hello" to the mother and for the moment slightly ignore the child; but before leaving say "Hello" or make some such friendly gesture. The child has met me in an environment similar to his own home, and not amid possible objects of fear such as the dental chair and the x-ray machine. An overly demonstrative approach either on the part of the dentist or the dental assistant should be avoided at all times, and particularly on first meeting the child. A "gushing" attitude is likely to suggest to the child that there is a "catch" in it somewhere. The dental assistant invites the mother and child into the operating room and leaves immediately. The mother will likely *ask* the child *if he will* get up in the chair. If he is a well-behaved youngster, as most children are, he will do so on this request and all will be well; but in some instances he will answer, "No." The mother then will attempt to lift the child into the chair. When such a situation arises, I tell the mother to remain for a few moments, but that she may have to go to the reception room. In a firm voice, and with just as firm an expression, I tell the child to get up in the chair. If he refuses the mother is told immediately to go to the reception room but not to worry as no corporal punishment

is intended. The procedure is repeated with an even more severe stare. If more dentists would curb their tongues and their tempers and instead use their eyes to control children, their success would be greater.

Dentist's Attitude

Posture at this point is extremely important. Stand up to be seen. No matter how firm your attitude might be, if you slouch while portraying it—failure will be the result. If a dentist is forced to lift a child into a chair, then no amount of persuasion will make him open his mouth later and submit to proper examination. But if by your command alone you are able to make him get up into the chair, then you are in full control of the situation. The child will realize this and voluntarily open his mouth. In my practice this system has never failed.

I never allow a child of three or four years of age to be left alone in a room. When I go out, I ask the dental assistant to come in and stay until I return. Generally speaking the mother is never invited into the operating room after the first appointment no matter what type the child may be.

Child's Fears

In handling small children one must remember two of the basic causes of fear; sudden loud sound, and sudden loss of support. No matter what temperament the child may have, before attempting to use the drill, I always place a rubber cup in the handpiece and administer it to the tooth to be restored. The rubber cup is replaced by a bur, and the action repeated; but the child is told that this will make a little harsher sound and that it may hurt a little. Often a child will be badly upset because the dentist tilts the chair without telling him. He then gets a "going-down-in-the-elevator" feeling and fear is the result.

Control of Child

I do not believe in holding a child or using the so-called "towel" method. To me this is an admission of defeat. Restriction of movement is one of the basic causes of fear, and such methods in this modern age do not uplift our profession in the eyes of present-day educators. We must be honest and frank with children. If we are truthful, they will respect us. If we are poor disciplinarians, we will lose their respect. I have often heard the teacher who has failed as a disciplinarian called a "jerk" or some such disrespectful title. When I have succeeded in impressing the child with the fact that it is I who gives the orders in the dental office and not the mother, I feel it is safe to display gradually a more playful and lighthearted attitude, but still with that reserve that makes the child realize that I am always in readiness to take command at any time. As each appointment comes around the child realizes that I am firm yet kind,

and in the majority of cases willingly enters the operating room alone when called by the dental assistant. If he is a little hesitant, I put in an appearance and usually a stare will bring results. I learned the "stare" method from a deaf-and-dumb parent. The way that they control their children with the eyes is amazing.

Fear of Child

Probably the extreme case, the problem child, is what worries most dentists. The statement that there are more dentists afraid of children than children afraid of dentists is a true one. For a number of years, particularly when I took the playful approach to children on their first appointment, I found myself hating to go back to the dental office after lunch for an appointment with a young child who might be difficult. However, today, whether it be experience or a new technique, I can say truthfully that all fear has vanished with respect to my treatment of children.

Up until a few years ago, I always recommended that children have general anesthesia for the extraction of even one tooth. Today I use local anesthesia except in multiple and infected cases. Some years ago I was giving a paper at the children's congress in Quebec City. I was talking about the causes and elimination of fear when one of the dentists with a strong French-Canadian accent told me that in his town the children did not know fear. They called him the "sleep doctor." He gave all children general anesthesia, even for operative treatment. It occurred to me then—and I told him so—that the fear was in him, not in the children of his town. Anesthesia was an escape method. I realized that that was what was wrong with me when I avoided extracting for children. The exodontist was my escape; the fear was in me. This was impressed still further when, in another audience sometime later, someone asked what were the general practitioners to do when there were no exodontists to which to send the children. I immediately felt that I must find the answer to this question. I did so by doing the extractions myself. From that day I have been using local anesthesia for extractions and my success is the result; first, of getting control of myself, and, second, of demonstrating that attitude in front of the child.

Handling Parents

What about the problem child who has visited all the dentists in the neighborhood? When a mother calls and tells me that she has a particularly nervous, high-strung, sickly child, and the previous dentist could not perform any dental treatment, I follow this procedure. I ask her to tell me all about the previous incidents and in so doing she usually exposes her own weaknesses to me. She tells me that she

(*Continued on page* 1394)

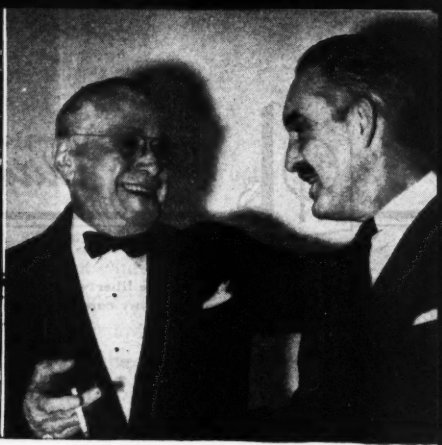
Portraits and Profiles

OF AMERICAN DENTISTS

By HOWARD A. HARTMAN, D.D.S.

Above: W. Wayne White, of Kansas City, Missouri, presents a desk set to Roy J. Rinehart, Dean of the University of Kansas City School of Dentistry, at a testimonial dinner given in Doctor Rinehart's honor by the Dental College Alumni Association.

Right: Fred Richmond, of Kansas City, Kansas, Secretary of the American Dental Association Insurance Committee.



Above: Francis M. Calmes, faculty member of the University of Kansas City School of Dentistry.

Top Right: George A. Esterly (left), guest of honor at the 75th meeting of the Kansas State Dental Association, is greeted by John M. Clayton, President of the Missouri State Dental Society. Doctor Esterly was President of the Kansas State Dental Association in 1907.

Above: F. C. Elliott, Dean of the University of Texas School of Dentistry, Houston, and Ralph R. Byrnes, Dean of Atlanta-Southern Dental College, Atlanta, Georgia, exchange greetings at the testimonial dinner for Doctor Rinehart.

Left: Officers of the Kansas State Dental Association: B. H. Crawford, immediate Past - President; A. E. Ricks, President; Clinton Stalker, President-Elect.

Editorial Comment

"Give me the liberty to know, to utter, and to argue freely according to my conscience above all liberties." ***John Milton***

THE TIME FACTOR IN DENTAL TREATMENT

FEW DENTAL operations, even the simplest, can be performed in less than twenty minutes. Dental appointments of less than thirty minutes are usually unproductive for both the patient and dentist. Some dentists do actually "see" twenty to twenty-four patients a day. "See" rather than "treat" is the proper word. In other days this kind of treatment was called "cotton changing." With the pressures of the last several years, however, even the most proficient members of the profession have been required to increase their patient load with often a consequent loss of quality in the service. This regrettable condition will be admitted by the men who were required to practice speedup dentistry.

A sensible editorial in *The New York Journal of Dentistry*[1] has shown that dentists cannot operate in any prepayment dental program until the time factor in dental treatment is acknowledged to be different from the treatment time element in medical practice. Physicians are able to care for more patients and to delegate important details to other persons; notably interns and nurses. The U. S. Public Health Service has reported a study that shows that the treatment time by physicians varies from 12.2 to 21.3 minutes for each patient.

The surgeon is able to perform a major operation often in less time than is required by a dentist to make a satisfactory inlay. Without regard to the comparative risks or skills required one can say that the surgeon, even under the reduced fees of a prepayment system, is still well compensated. In any prepayment system, whether under compulsory governmental or voluntary private auspices, the dental profession should

[1]Editorial: Differences in Patient Treatment-Time for Dentists and Physicians, N.Y.J.D. 16:53 (February) 1946.

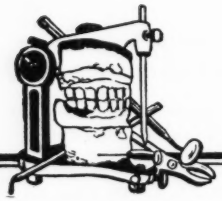
not make the mistake of agreeing to furnish dental care at a greatly reduced fee schedule. To do so would be to produce bankruptcy among dentists.

The treatment time factor is such in dental service that even under the most efficient systems the time per patient cannot be greatly reduced. This means that a dentist is limited in the number of patients that he can treat in a day. Naturally, if he has efficient assistants and a well-organized routine, he can increase his productivity. But the margin of diminishing productivity is reached early in dental practice. A dentist may be able to treat fifteen or sixteen patients in a working day. If, however, he forces himself to meet more than that number his productivity reaches the marginal limit and begins to drop rather than rise. A sure way for a dentist to lose money is to attempt to "see" too many patients in a working day. If, as an example, a dentist is able to give proper attention to fifteen patients a day and under a prepayment system he is asked to perform the services for $2 less per unit it is readily seen that the dentist reduces his income by $30 a day. No dental practice can tolerate such a reduction in income.

If dentists working under any group payment system insist on quality dental care at a fair fee schedule we can be assured that both the dentist and the patient will profit. A dental fee based on a comparison with medical fees would be disastrous. The physician spending three or four office hours a day meets more patients than the dentist does in his entire working day. In the hospital routine the physician is not ordinarily required to spend hours in individual patient treatment. The physician acts in the hospital in a supervisory role. Actual treatments are done by interns, residents, and nurses. The dentist has not the legal sanctions to delegate any important amount of actual treatment to others.

Whenever we plan a dental program on a group basis we should keep in mind the uniqueness of dental treatment and how it differs from medical treatment.

Edward J. Ryan



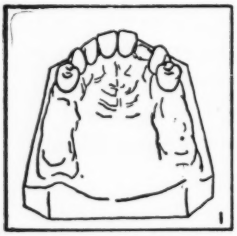
Technique of the Month

Conducted by W. EARLE CRAIG, D.D.S.

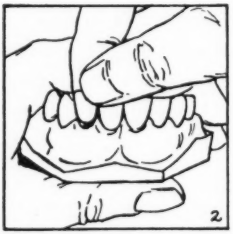
Drawings by Dorothy Sterling

Strengthening a Single Tooth on a Partial Denture

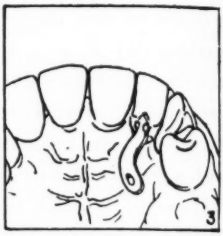
By LEONARD S. FLETCHER, D.D.S.



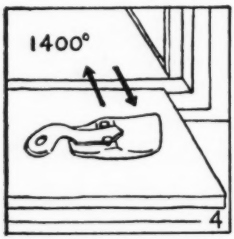
Cast of case showing the upper left lateral to be supplied on the partial denture.



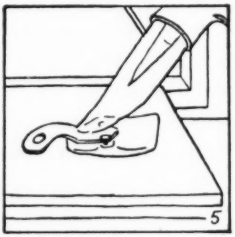
Select and grind the tooth into position.



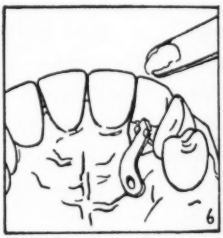
Fit a lug between the pins on the tooth or shape wire around the pins.



Preheat the tooth at the entrance of the furnace for two minutes. Then place the tooth inside the furnace for 3 minutes at 1400°F.



Bring the tooth to the shelf in front of the furnace and, with low fusing solder and the open flame of a blow torch, solder the lug to the pins.



Allow the tooth to cool in the air by holding it in lock tweezers. Set the tooth on the model and proceed with waxing in the usual manner.

Ask Oral Hygiene

Please communicate directly with the Department Editors, V. Clyde Smedley, D.D.S., and George R. Warner, M.D., D.D.S., 1206 Republic Building, Denver, Colorado, enclosing postage for a personal reply.

Sulfonamide Allergy

Q.—For the last two or three years I have placed routinely a mixture of sulfanilamide and sulfathiazole powders in sockets after extraction with uniform control of infection. I cannot remember a dry socket during that time.

One patient, a woman, 25, returned the next day with large red and purple blotches, circular, about two to four inches in diameter, on her back and chest. She said she had the same experience from two doses of an intended course of sulfa treatment for a respiratory infection a year before. Both times the spots took a month or more to disappear. No other symptoms except itching in the spots occurred.—C. H. B., California.

A.—Thank you for your letter on allergic manifestations following the use of sulfonamides in tooth sockets. While I am familiar with the fact that a good many people are allergic to the sulfonamides, I had assumed that as little as is used in a tooth socket, from which only part goes into the circulation, could not cause such reactions as you describe. I am, therefore, especially glad to have your letter.—GEORGE R. WARNER.

Extreme Swelling

Q.—We all have had any number of swollen faces confront us, but the one I had today was my most serious. The patient had noticed the swelling for two weeks before seeking any dentist's advice. Heat had been applied which the patient said made it swell more; then cold was applied with no results. I tried to incise the gingiva but no pus exuded which I thought strange for such a large swelling. What is your procedure in a case like this?—H. A. S., Pennsylvania.

A.—In your letter you give no details as to the location of the swelling or the probable cause. Our procedure would be first to roentgenograph the area of the swelling to find the cause. If a tooth or root were the cause we would evaluate its present condition and decide if it would be safe to remove the tooth or root. In any event, we would put the patient on intramuscular injections of penicillin for from twenty-four to forty-eight hours, or have a physician give the treatment. It would then be safe to remove the cause of the swelling or drain the abscess if fluctuation could be detected.—GEORGE R. WARNER.

Pain in Maxillary Joint

Q.—I have a patient, a man about fifty years of age, who had all his teeth extracted. I made him dentures and he has had them relined. Everything is satisfactory with regard to the dentures as to function; but in the last month he has been experiencing a pain in the region of the temporomaxillary joint when he opens his mouth wide and also when he moves the mandible laterally.

This pain is just on the left side. Could it be in the nerve ganglion, as the pain follows down under the ear? When he opens his mouth about one-half inch, there is no reaction; but from there to a full opening, he experiences this pain. I noticed in his roentgenograms at the time of his extractions that the bone structure appeared to be honeycombed, and I have been told that that indicates a glandular disturbance.—T. P. C., Nebraska.

A.—I would suggest a complete roentgenographic examination of this man's jaws and temporomandibular joints. Such a pain can be caused by a closed or unbalanced bite. Or there could be a breaking down of the bone structure. Good roentgenograms should disclose either of these conditions.

I strongly advise immediate consultation with a physician to determine why the bone structure is honeycombed.—V. CLYDE SMEDLEY.

Cankers

Q.—Will you please advise me what you have found the most effective method for treating cankers?—A. T., Illinois.

A.—Touching the center of a canker with a saturated solution of trichloractic acid, having the area dry, will give the quickest relief of anything of which I know, and will usually prove a cure. But cankers are often, if not always, an evidence of food allergy so that matter should be investigated.—GEORGE R. WARNER.

Abscessed Tooth

Q.—I have two questions to ask.

1. What do you think is the best procedure for a general practitioner without facilities for administering general anesthesia to follow in a case of an acute periapical abscess in the maxilla? I refer to the usual emergency case accompanied by edema and acute pain. Should palliative treatment be used, in which case immediate relief is not obtained? Should incising and drainage, which is quite unpleasant even with ethyl chloride, be accomplished? Or should the patient be referred to a dentist who can remove the tooth under general anesthesia, which to my mind is the best treatment if the tooth must be sacrificed? Is it possible to treat these patients with satisfactory results (quick relief) without admitting them to the hospital?

2. On three occasions I have extracted teeth that were tender to percussion. The procaine took prompt effect and the extractions were painless. However, immediately following the removal of the teeth, the patients experienced extreme pain in the sockets which lasted for about ten minutes. Can you explain this occurrence and suggest a method for its prevention?—R. L. S., Pennsylvania.

A.—1. In our opinion it is the best practice never to extract an acutely abscessed tooth with either a local or general anesthetic. Instead, palliative measures should be employed until acute inflammation has subsided, at which time a local anesthetic may be employed with safety.

2. There seems to be no way to foretell the rare instances in which pain occurs immediately after the extraction of a tooth under procaine anesthesia. If we could predict or anticipate these cases, the pain could be prevented by premedication with one of the barbiturates.—V. CLYDE SMEDLEY.

Missing Upper Central

Q.—I have a patient, a girl 14 years old, for whom the right upper central had to be removed because of an accident. I shall appreciate your advice with regard to a restoration. I believe she is too young for a fixed bridge.—A. R., Kansas.

A.—It would seem best to make a temporary bridge, supported by

well-fitted orthodontic bands on the left upper central and right lateral, for the patient. This temporary bridge should be taken off every six months to one year for prophylaxis and recementing. The teeth should be checked with roentgenograms occasionally when the temporary bridge is off; and when you think the pulps have receded sufficiently to make it safe to do so, a permanent bridge can be made with anchorage into the right lateral and left central, preferably with the pin-ledge type of well-fitted hard gold inlays.

If you prefer, for any reason, to supply this right upper central with a partial denture, I would suggest that it be made to cover the palate without any tooth contact and without any attachments. It is remarkable how most children will learn to tolerate a loose palate appliance. I think, however, that the temporary bridge is better.—V. CLYDE SMEDLEY.

Chancre of Syphilis

Q.—In my practice in the past I have had occasion to see in the oral cavity what appeared to be the primary chancre of syphilis. My procedure usually was to send the patient to a neighboring physician for a Wassermann test. The physician would take the test, and in every case the test report was negative.

Lately I have been given to understand that when the patient presents himself with a chancre *present*, his blood is still in a sero-negative state and the Wassermann test is, therefore, negative at this time.

1. Is the last statement true?
2. If so, how long after the appearance of a chancre does the Wassermann test become a true test of the presence of syphilis?
3. What is the usual length of time that the chancre (primary) remains if the patient is untreated?
4. What is the usual length of time that the chancre remains if treated by a physician?
5. If a lesion appears upon the lips of a patient and heals within forty-eight hours, can I assume that it was not a chancre?
6. If a patient with a chancre begins anti-syphilitic treatment with a physician, how soon can I assume that he is not a source of contagion?—S. B., New York.

A.—In answering your questions, I will answer by number.

1. Yes.
2. Three weeks or more.
3. Two to three months.
4. Ten days.
5. You can.
6. Twenty - four hours after treatment is started.—GEORGE R. WARNER.

THE COVER

COLONEL JAMES P. HOLLERS (DC), of San Antonio, Texas, with General of the Army Dwight D. Eisenhower as he greets members of the Reserve Officers Association at their national convention in Chicago. The San Antonio dentist is President of the Association.—*Chicago Sun Photograph.*

CAN YOU USE A DOLLAR?

TO EVERY READER who contributes a newsworthy item, something unusual about a dentist, *which is published in Dentists in the News* (see page 1374), we will send promptly a crisp, new one dollar bill. Every clipping must be taken from a newspaper and carry the name of the publication and the date line. Clippings submitted cannot be returned. When more than one copy of a clipping is submitted, the first one received will be used. Send all items to Dentists in the News, ORAL HYGIENE, 708 Church Street, Evanston, Illinois.

SO YOU KNOW SOMETHING ABOUT DENTISTRY!

Answers to Quiz XXIII

(*See page* 1369 *for questions*)

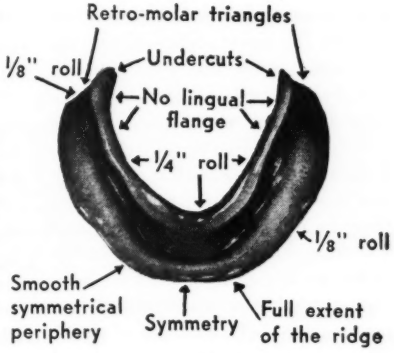
1. An occlusal relation of the teeth that causes repeated injurious strain on the supporting tissues of the teeth. (McCall, J. O.: Fundamentals of Dentistry in Medicine and Public Health, Macmillan, 1938, page 51)
2. Anterior palatine nerves and the greater palatine arteries.
3. (c) ethyl chloride. (Accepted Dental Remedies, 10th Edition, American Dental Association, 1944, page 244)
4. Mechanical working of the structure above recrystallization temperature. (Skinner, E. W.: The Science of Dental Materials, 2nd Edition, Saunders, 1941, page 185)
5. (b) allow investment setting expansion to take place. (Skinner, E. W.: The Science of Dental Materials, 2nd Edition, Saunders, 1941, page 285)
6. (c) apically from the middle portion of the root. (Tylman, S. D.: Crown and Bridge Prosthesis, C. V. Mosby, 1940, page 105)
7. (b) high fusing. (Tylman, S. D.: Crown and Bridge Prosthesis, C. V. Mosby, 1940, page 482)
8. (c) greater than the mesiodistal width of the succeeding bicuspids. (Brauer, J. C.; Higley, L. B.; Boyd, J. D.: Dentistry for Children, Blakiston, 1939, page 126)
9. (a) 9 per cent. (Brauer, J. C.; Higley, L. B.; Boyd, J. D.: Dentistry for Children, Blakiston, 1939, page 11)
10. (b) apex of the root. (Ennis, L. M.: Dental Roentgenology, 3rd Edition, Lea & Febiger, 1939, page 96)

1947 CHICAGO MIDWINTER MEETING DATES SET

THE 1947 MIDWINTER Meeting of the Chicago Dental Society will he held from February 10 through 13 at the Stevens Hotel, according to a recent announcement made by Doctor Robert J. Wells, Secretary. The Society's officers are planning a program of wide interest similar to those held before the war since they expect that travel and hotel accommodations will be readily obtainable at that time.

431. *Every Mucosal-Seal denture should have the landmarks illustrated. If it does not, it is not a typical Mucosal-Seal lower denture, although it may still exhibit surprising retention.*

A TYPICAL
MUCOSAL-SEAL LOWER DENTURE



432. *In over one-hundred cases to date no mouth has been found that does not exhibit the typical landmarks as illustrated. These cases include at least 25% that were previous complete failures.*

433. *In all of the cases, second degree retention was obtained and in the majority of cases, third degree retention was demonstrated. These cases are available for inspection.*

434. *It is interesting to note that all of the cases have retained their retention up to two years, and that the occlusion is now as perfect or better than when the dentures were originally inserted.*

435. *This maintenance of retention is entirely due to the DENTA PEARL CYCLO-MOLD acrylic teeth. These teeth wear the same as natural teeth and constantly maintain occlusion. The maintenance of occlusion in turn equally distributes the pressures over the entire ridge, thus minimizing alveolar absorption.*

CHILD PSYCHOLOGY THAT PAYS

(*Continued from page* 1383)

could not possibly leave the operating room, for the dentist was this, that, and the other thing. Then I start in by telling her that I will accept the case on one condition, and that is that the child must be under my jurisdiction from the time he enters the reception room door. She is told that the mother is never allowed in the operating room, and the child will not be slapped, gagged, or mistreated in any way. Usually there will be a lull in the conversation. I then explain that if this procedure is not agreed to, my time and their money are being wasted, and I would rather that they would not make an appointment. Those who do not make an appointment are few and you are well rid of them. The mother is warned beforehand that the child may have to be carried from the reception room but once out of her sight he is placed on his feet, and the method previously described carried out. If the mother interferes, I refuse to go any further; and again in most cases she yields.

Obstreperous Child

When such a child gets into the chair he usually cries loudly, kicks, and uses his hands freely. With a steady stare look him straight in the eye and then commence looking into his mouth. He will put up his hands, but do not slap them for that would be breaking faith with the parent. I usually clasp the hands in mine and in a quick, throwing motion force them into his lap.

When a child visits my office for the first time, I always carry out some dental operation. Some believe in doing nothing the first day, particularly if the child refuses to get into the chair. In my opinion, if we let him out of the office after he has refused to cooperate, he has won the first round, and the second appointment will be more difficult.

I do not spend all day scowling at children; on the contrary, I love children and would rather treat any child no matter how difficult than the most cooperative adult. My days are full of pleasure because of my association with children, but I am trying in this article to counteract many of the time-wasting, commercialized methods that are recommended in managing children in the dental office. Everywhere I go I hear from the general practitioner, "I would be willing to treat children if I had the time to play around with them." Those of us who are attempting to encourage more dentists to serve children must show them how it can be done economically, but it cannot be if we recommend a "Cook's Tour" for every child who enters the office.

Toronto, Canada

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Laffodontia

Steno: "I wish to buy a fashionable dress."

Clerk: "Yes, miss, will you have it too tight, too short, or both?"

★

Hi diddle diddle, the cat and the fiddle.
He called his sergeant a goon,
The MP laughed to see such sport
Court Martial—Tomorrow noon.

★

A man was arraigned for assault and battery and brought before the judge.

Judge: "What is your name, occupation, and what are you charged with?"

Prisoner: "My name is Sparks, I am an electrical engineer, and I am charged with battery."

Judge (after recovering his equilibrium): "Officer, put this guy in a dry cell."

★

She: "I nearly fainted when the fellow I was out with last night asked me for a kiss."

He: "Baby, you're gonna die when you hear what I have to say."

★

Prof. (to senior): "Spell 'straight.'"

Senior: "s-t-r-a-i-g-h-t."

Prof.: "Correct—and what does it mean?"

Senior: "Without ginger ale."

★

"There is nothing wrong with you," said the army doctor to the recruit up for examination. "Your pulse is like clockwork."

"Well, what do you expect?" the recruit replied indignantly. "You've got hold of my wrist watch!"

Teacher: "What is your idea of harmony?"

Smart Boy: "A freckled face girl in a polka dot dress and a leopard coat, leading a giraffe."

★

Until I heard a doctor tell,
"There's danger in a kiss."
I had considered kissing you
The closest thing to bliss.
But now I know Biology,
And sit and sigh and moan,
Six million mad Bacteria
And I thought we were alone.

★

First Actor: "I'm getting on. Somebody has named a cigar after me."

Second Actor: "I hope it draws better than you do."

★

Mother: "Who taught you that wicked word?"

Small Son: "Santa Claus."

Mother: "Santa Claus?"

Son: "Yes, when he stumbled over my bed on Christmas morning."

★

"Say mister, could you let me have a dime for a cup of coffee?"

"I thought coffee only cost a nickel."

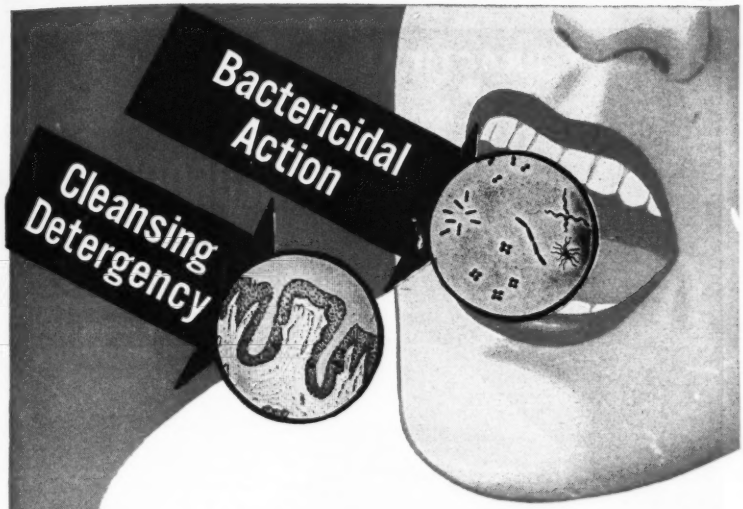
"It does, but I'm keeping a woman."

★

She: "You shouldn't make love to me, my husband has a title."

He: "Phooey, I'm an American. Titles mean nothing to me."

She: "O.K. big boy, but don't say I didn't warn you. My husband has the heavyweight title."



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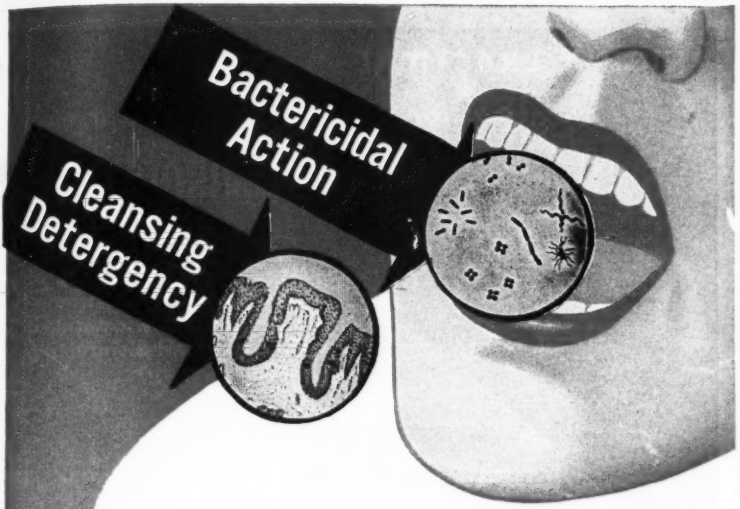

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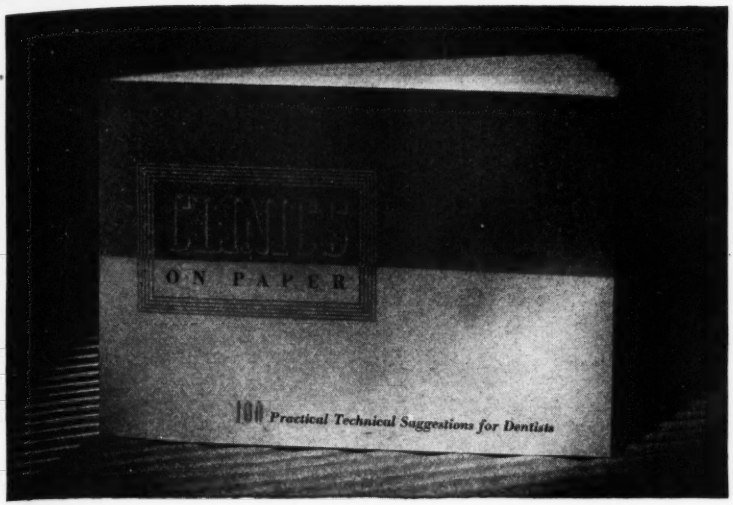

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☐ Here is $1.00 for a copy of the new book CLINICS ON PAPER. I am a regular subscriber.

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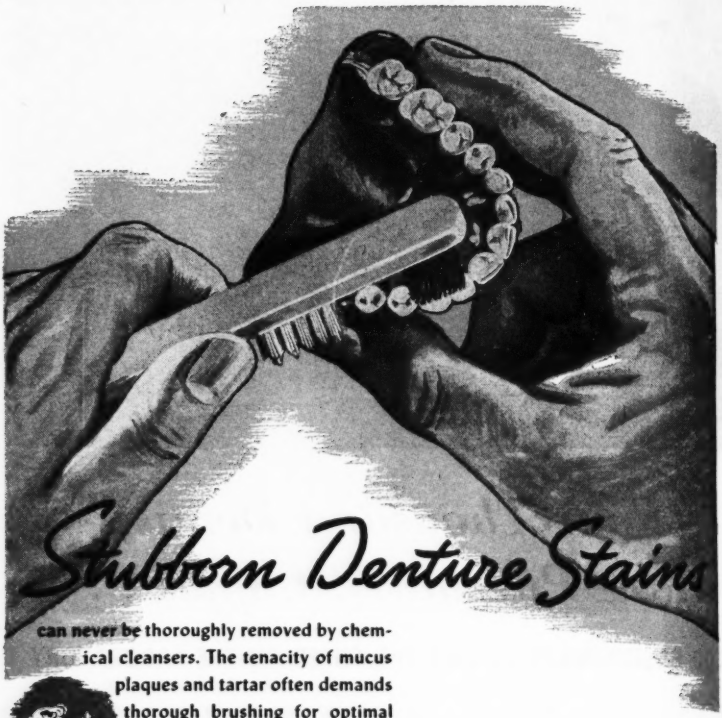
Dr. .....

Address .....

Dealer .....

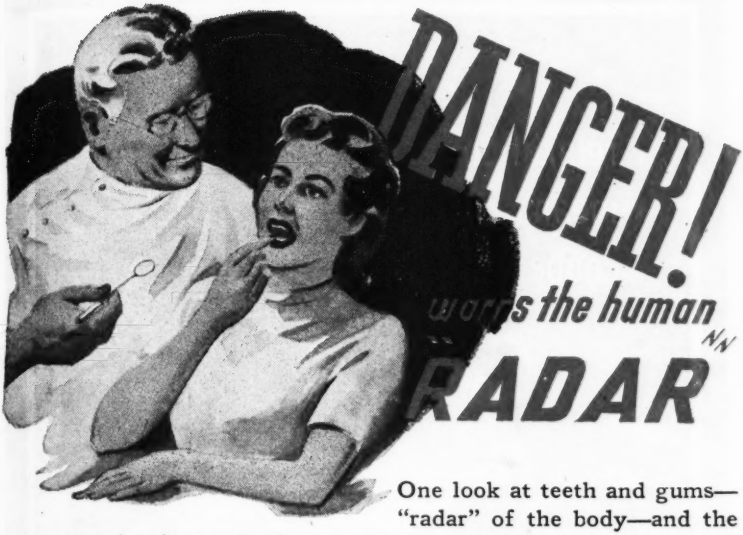


Stubborn Denture Stains

can never be thoroughly removed by chemical cleansers. The tenacity of mucus plaques and tartar often demands thorough brushing for optimal mouth hygiene. • Only functional correctness in the design of a plate brush, and the non-abrasive creamy consistency of a detergent . . . as exemplified by Dr. Wernet's Plate Brush and Wernet's Dentu-Creme . . . can assure the best possible care for modern dentures.

WERNET DENTAL MANUFACTURING COMPANY
190 Baldwin Avenue, Jersey City 6, N. J.
126-H

DR. WERNET'S PLATE BRUSH
WERNET'S DENTU-CREME
Only a Brush Can Remove a Stain



One look at teeth and gums—"radar" of the body—and the alert dentist instantly knows his patient's nutritional status[1]. Because subclinical scurvy (C-avitaminosis) does not resemble the classical picture of scurvy, the dentist will often "spot" the case before the physician.

Says Massler[2]: " . . . the alveolar bone and the gingivae reflect the present nutritional status of the body as quickly as a thermometer reflects the temperature . . . The earliest sign of a frank or subclinical vitamin C deficiency is often a painful gingivitis with bleeding upon the slightest trauma."

SODASCORBATE, the only sodium ascorbate in dry, neutral form, is ideal for the Dentist who wishes to prescribe vitamin C for long-continued use. Each tablet (120 mg.) provides 100 mg. of vitamin C activity. The sodium salt of ascorbic acid helps to obviate gastric upsets, laxative action and acid-shifts that so often follow the use of straight ascorbic acid.

The average dose for adults is one tablet t.i.d.; or as indicated by the condition. For children under 12, one-half tablet t.i.d. May be dissolved in milk for babies and young children.

Supplied in bottles of 40 and 100 tablets, also "hospital-size" bottle of 500 tablets. For samples and literature, sign and mail the coupon.

[1]Linghorne, W. J. et al. Canad. M.A.J. 54:106, 1946.
[2]Massler, M. Am. J. Pub. Health 35:923, 1945.

SODA-C

SODASCORBATE

VAN PATTEN PHARMACEUTICAL CO.
500 North Dearborn, Chicago 10, Ill. OH-8

Please send professional samples of SODASCORBATE and new monograph, "Vitamin C in Dentistry."

Dr. _____

Address _____

Town _____ State _____

Application of the Stader Splint in Managing Fractures of the Mandible

The Stader External Reduction and Fixation Splint is eminently practical for the management of fractures of a completely edentulous mandible These fractures, often bilateral or multiple, are difficult to reduce and maintain in proper position. Immediately after the application of the Stader Splint and reduction of the fracture, the patient has use of his jaw with little or no discomfort

In extensive trauma with loss of bone substance and marked interruption of bone continuity, the Stader Splint will maintain normal position, preserve contour, permit healing without muscle contracture, and facilitate bone grafting and reconstructive surgery

The Stader Jaw Splint affords freedom of jaw motion, permits adequate care of the mouth and teeth, simplifies after-care of the fracture, and provides a comfortable, painless convalescence for the patient

For complete information, address: General Electric X-Ray Corporation, 175 West Jackson Boulevard, Chicago 4, Illinois. Dept. 2579.

GENERAL ELECTRIC X-RAY CORPORATION

Temporary Assistance

BEFORE A CHILD is able to walk by himself, he needs the guiding hand of his mother. • The new denture wearer may need help, too! By providing a resilient cushion and by strengthening the seal between dentures and gums, WERNET'S POWDER gives helpful assistance until, by proper muscular control and tissue adaptation, the patient is able to retain and use his dentures comfortably and efficiently.

WERNET'S POWDER

INSURES DENTURE STABILITY AND RETENTION

Free Supply
on Request
WEIDENT DENTAL MFG. CO., INC.
190 BALDWIN AVE.
JERSEY CITY 6, N. J.

Both Dentist and Patient
BENEFIT FROM RADIOGRAPHY

THE dentist benefits because complete, thorough examination of a patient's mouth can be made easily and quickly with radiography. He saves time . . . gives better service.

The patient benefits because x-ray examination reveals more cavities, earlier, than can be found with instrumental examination alone . . . makes possible discovery and treatment of conditions that could not otherwise be found until complicated situations had developed.

Since the first application of x-rays in dentistry, materials provided by Kodak have helped dentists get maximum quality in their radiographs. Today, Kodak makes available through your dealer a complete line of materials for efficient, timesaving procedure—films . . . chemicals . . . accessories for exposure, processing, and viewing.

EASTMAN KODAK COMPANY
X-ray Division
Rochester 4, N. Y.

Kodak

"Family Traits" are so obvious it would be difficult to overlook them. Hence, ages before genetics became a science, a proverb—"*The apple falls not far from the tree*" recorded the phenomenon of heredity.

So, characteristics of teeth and their arrangement in the dentition are known to be inherited from one generation to another. Where no other record is available, nature thus provides a "living" model for scientific selection of teeth in edentulous cases.

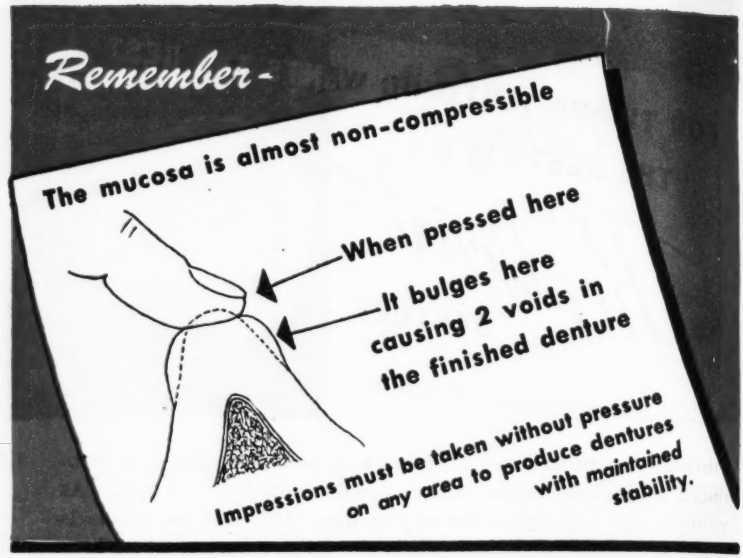
The dentition of a brother, sister, child or grandchild presents the most probable pattern of labial characteristics.

How do Five-Phase Anteriors help to facilitate such a procedure? Instead of the usual "fixed patterns", Five-Phase Anteriors provide: 1. *Varied labial surfaces* characteristic of natural teeth. 2. *Co-acting proximal contacts*—for easiest set-up and transposition of laterals. 3. *Veri-chrome colors*—following nature's plan of controlled brilliance. . . . PLUS simplified color matching. 4. *Superior porcelain*—simulating natural tooth structure in depth, refraction and translucency. 5. *Co-ordinate size system*—for easier selection.

In short, Five-Phase Anteriors are distinctive in that they possess the lifelike individuality of natural teeth . . . the only means by which all the living characteristics of the patients' teeth may be reproduced in the artificial denture. ★ ★ ★ ★ ★ ★

BE SURE TO SPECIFY WITH THE VERI-CHROME COLOR GUIDE

ANTERIORS



Zorite IMPRESSION CEMENT is a pleasant, resinous cement which (unlike plaster or oil-pastes) sets harder than compound by action of moisture in the tissue. *It produces an exact, detailed negative of the mucosa in passive, normal state —and thus, a denture in uniform contact with tissue.*

It has many advantages: Highly accurate, no separation media necessary, setting time under positive control, may be used as temporary rebase for weeks. Rounded, full functioning peripheries may be added by using our new Synthetic Impression Wax.

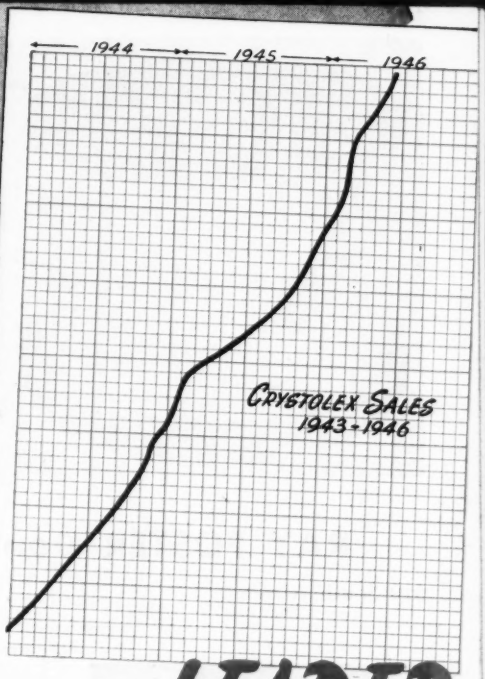
Synthetic IMPRESSION WAX, a new Bosworth product, is hard at 70° F., rigid at 85°, has 98% plus flow at 98.6°. It adheres well to dry surfaces and may be applied easily with fingers by flaming.

Thru your dealer. Write for full information.

HARRY J. BOSWORTH COMPANY

1315 SOUTH MICHIGAN AVENUE • CHICAGO 5, ILLINOIS

EVERY DENTIST *Should Know*



THAT THERE'S A *LEADER* AND A REASON WHY . . .

● Leadership in dental acrylics can be won only through actual performance. The steady climb of Kerr Crystolex sales, charted above, is plainly in evidence. And for very good reason.

Crisis in the fit of every denture is the period of actual polymerization.

Does the chosen acrylic cure almost instantly when that crisis comes? . . . With sudden shock and terrific self-generated heat in the thicker parts? . . . If so, look out for internal strains and results which, at best, will call for your reluctant correction at the chair.

Much better, specify Crystolex 102, the acrylic which cures slowly, uniformly and with only normal exothermal heat . . . The acrylic with BUILT IN CURE CONTROL . . . The acrylic which therefore processes into dentures of RELIABLE FIT.

KERR DENTAL MFG. CO. Established 1891 DETROIT 8, MICHIGAN

KERR *Crystolex* FORMULA 102

The
ANALGESIC FOR HOME USE...

THE Bayer Laboratories at Rensselaer, N. Y., have specialized in the production of Aspirin for over forty-seven years. Only the finest and purest ingredients are used in its manufacture. Every batch made is subjected to complete and rigid scientific controls. Seventy different tests and inspections have been developed to insure the quality, purity and uniformity of the finished product.

BAYER *ASPIRIN*

Absolute impenetrability guarantees that oral fluids containing acids and bacteria cannot seep through a cementing medium to loosen appliances or develop secondary decay. Absolute impenetration guarantees added years of service from the cementation.

Fleck's Zinc and Red Copper cements are absolutely impenetrable! That is one reason why it has been used so successfully and by more dentists than any other cementing medium. Proof of impenetrability is easily demonstrated in the following test.

Shape a mix of Fleck's cement into a pellet and allow it to set to consistency of thick putty. Immerse pellet in aniline dye solution for at least three weeks. Remove pellet and split in half as shown in illustration. In this test, where even the slightest penetration would show dye color below the external surface, both Fleck's cements *will show clean, uncolored cross sections!*

The full significance of this experiment is multiplied when you consider that even the slightest penetration would be sufficient to permeate the full depth of the average cement film.

CEMENT

NEW YORK 10, N. Y.

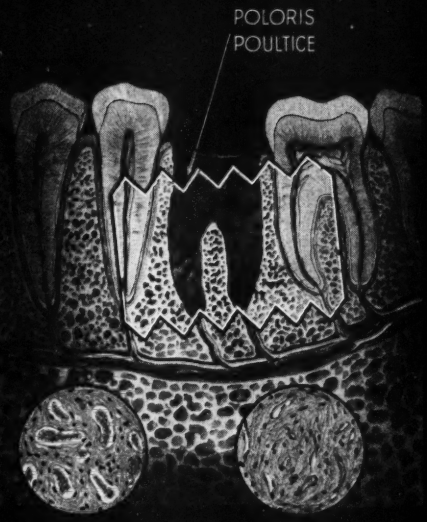
PERMANENT

The timeless beauty of a Lucitone restoration is as definite and predictable as the end result of the combination of two parts hydrogen and one part oxygen. With the latter, the end result is always water. With Lucitone, the denture is always lifelike and permanently stable.

Lucitone's color is not a mask hiding oral tissue. Instead, individual tissue coloration shows through, becomes an intrinsic part of the restoration . . . defying detection, giving complete confidence to the wearer.

In addition, Lucitone's permanent stability means not only that a Lucitone replacement conforms to every convolution of the original impression and model, but also, that it stays that way permanently. Once molded and in constant use in the mouth, Lucitone stays the same size and shape. Its first dimension (the impression) is its last dimension.

Added together, Lucitone's advantages spell patient satisfaction and complete approval and confidence year after year.



Ischemia—retarded capillary action arising from vasoconstriction

Normal capillary action

Apply **POLORIS** *buccally and as closely as possible to painful or congested area.*

for example:

POST-EXTRACTION PAIN

Pain after routine extractions frequently arises from ischemia, after-effects of local anesthesia, or low tissue resistance. Stimulation of capillary activity with **POLORIS** Capsicum-Benzocaine Dental Counterirritant will help to bring about a return of normal circulation, with concurrent control of local pain and soreness, and without the necessity of using systemic drugs. A professional supply of **POLORIS** will be sent on request. Write to

POLORIS COMPANY, INC., 12 HIGH ST., JERSEY CITY 6, N. J.

26-H

The element of control—involving the degree and character of anesthesia desired—is always in your hands when PROCO-SOL is your choice of an injection anesthetic. Due to careful construction of tubes and stoppers, the amount used and the rate of injection are easily regulated.

With PROCO-SOL adequate potency is combined with maximum safety and minimal post-operative reactions.

Write us direct for **FREE SAMPLES,** *or consult your Dental Supply Dealer on regular quantities.*

Proco-Sol

PROCO · SOL BRAND

CHEMICAL CO., INC.

58th & MARKET STREETS • PHILADELPHIA 39, PA.

COLOR

TO MATCH THE INDIVIDUAL COMPLEXION

THE ACRYLIC FOR DENTURES OF DISTINCTION

A wide range of pink from light to deep . . . to satisfy the most discriminating patient.

DURABLE • NO DISTORTION • STRONG • LIFE LIKE

McCormick's

KORMIX

Jewel Tone

THE ACRYLIC

TAKE ADVANTAGE OF THIS "GET ACQUAINTED" OFFER

Regular One-Half pound size (12 units) any shade

$4.00 VALUE for ONLY $3.00

a product of

E. J. McCORMICK RUBBER CO., Inc.

RIDGEFIELD PARK, NEW JERSEY

Manufacturing for the Dental Profession for over 60 years

Distributors

Midwest — Brown Dental Mfg. Co. Chicago, Ill. London — Davis, Schottlander & Davis

COLORS

1. Pearl Pink
2. Topaz Pink
3. Diamond Rose
4. Ruby Rose
5. Carnelian Red
6. Garnet Red

SEE YOUR DEALER FOR THE HANDY KORMIX SHADE GUIDE MADE OF THE ACTUAL MATERIAL

E. J. McCormick Rubber Co., Inc. Ridgefield Park, N. J.

Please send me ½ lb. size KORMIX at your special price of $3.00.

Specify Shade:

1..... 3..... 5.....

2..... 4..... 6.....

Check Enclosed is $3.00 ☐

one: Charge my dealer ☐

Name .....

Address .....

Dealer .....

Address .....

To help your Denture Patients through the "Critical Period"

35¢ Size

This improved adhesive denture powder is especially indicated during the first few months of accommodation to a denture.

PERMA-GRIP will go far to alleviate the sense of insecurity and discomfort so frequently manifested by denture patients during that critical time when gums are shrinking and a final adjustment is yet to be made.

The correct proportion of Karaya Gum, carefully controlled as to viscosity, gives Perma-Grip unusual holding power without danger of irritation. It will not "ball up," but remains a smooth, gentle cushion. It is pleasant in taste and color. The pH is adjusted to mild alkalinity.

Recommendation of Perma-Grip has frequently served to create added good will between doctor and patient. Manufactured by the Pro-phy-lac-tic Brush Company, it is backed by over 60 years' experience in the field of dental hygiene. Send coupon for samples.

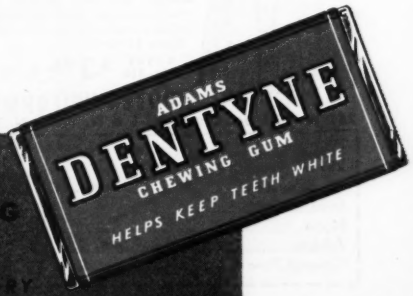
Backed by Over 60 Years' Experience in the Field of Dental Hygiene

Pro-phy-lac-tic Brush Co.,
Florence, Mass.

PRO-PHY-LAC-TIC BRUSH CO.
DEPT. 8-O
FLORENCE, MASS.
Gentlemen:
Please put me on your mailing list to receive_____professional samples of Perma-Grip each month.
Name_____
Street_____
City_____

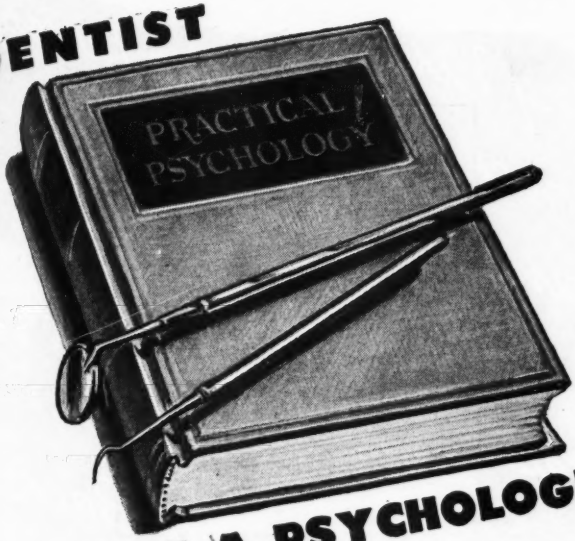
BUT GOOD FOR THE TEETH

Hard to take? Maybe...but it helps to explain "clean as a hound's tooth"! Indeed, because vigorous mastication tends to limit the deposition of calculus on exposed teeth or under the free gingival margin, it is regarded as "*the most effective prophylactic against tartar formation*" —so frequently premonitory of serious gingival and alveolar pathologies. • That is why the use of Dentyne Gum—with its specially firm consistency—is often recommended as extra-masticatory exertion to "tartar-susceptibles." Its delightful flavor renders its routine use particularly pleasant for patients, both young and old.



Dentyne CHEWING GUM
THE IDEAL MASTICATORY

A DENTIST



MUST BE A PSYCHOLOGIST

To insure patient cooperation, a dentist should apply everything he knows about human nature.

One thing he knows, for example, is that people don't like to work hard...they prefer doing things that don't require much effort.

And realizing that correct tooth brushing is *exacting*, the wise dentist simplifies things for his patients by recommending the D.D. Tooth Brush—the brush that makes scientific brushing *easy*.

For the ingenious *twisted-handle* facilitates proper placement of the brush on the teeth...almost automatically insures desirable *rotary motion*. Leading periodontists acclaim the non-skid thumb rest which permits easy control of the compact brushhead for gentle, non-traumatizing gum massage.

A Product of
BRISTOL-MYERS COMPANY

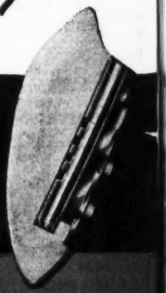
D.D.
DOUBLE DUTY
TOOTH BRUSH

630 FIFTH AVE., DEPT. 4
NEW YORK 20, N. Y.

*Unretouched photo shows patient with Steele's P.B.E. facings replacing lost upper centrals and laterals

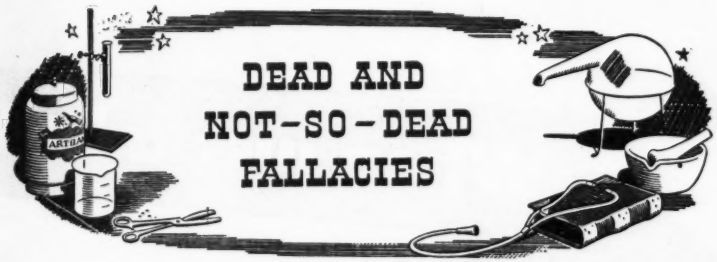
An old story to you now, but always a new thrill to your patients . . .

Porcelain Biting Edges



Use Steele's P.B.E. (Porcelain Biting Edge) facings for best esthetics — and always with Steele's P.B.E. backings.

THE COLUMBUS DENTAL MFG. CO. • COLUMBUS 6, OHIO



DURING the 19th century, hay fever was popularly believed to occur most frequently in persons belonging to the upper classes of society. This belief persisted for a long time before it became known that hay fever is no respecter of persons.

TODAY, many people believe that it is not safe to leave food in open cans. Many a housewife religiously empties the contents of cans into dishes often not so sterile as the can itself. It's just as safe to keep food in cans, so long as the container is kept cool and covered, according to the Dept. of Agriculture.

CANCO

AMERICAN CAN COMPANY

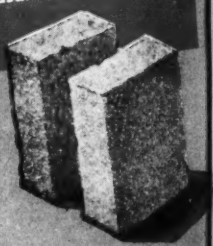
NEW YORK · CHICAGO · SAN FRANCISCO

NO OTHER CONTAINER PROTECTS LIKE THE CAN

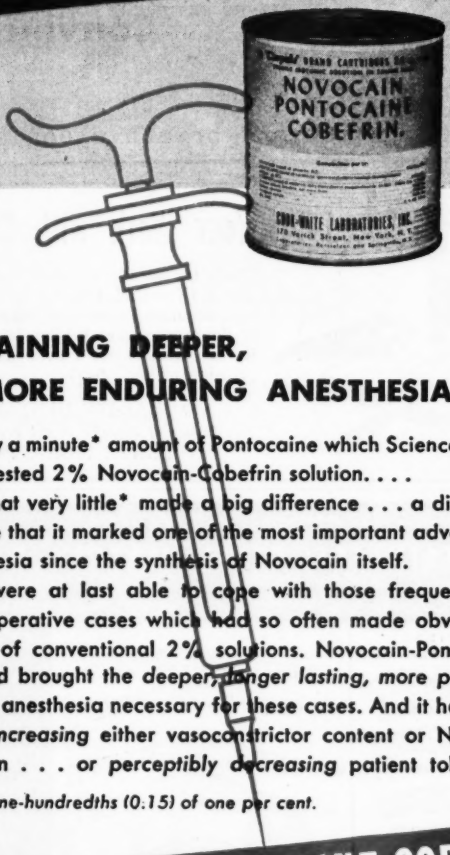
When just a little

IN SWEETENING FOODS . . .
MEDICAMENTS . . . SYRUPS

Just a little saccharin goes a long way! Being 500 times sweeter than cane sugar, a single tiny pellet of this "synthetic sugar" is equal to two lumps of the ordinary variety. Its discovery in 1879 was an event of signal importance not only to many brenches of industry, but also to medicine, where, because it does not elevate the blood sugar, it was able to make life more pleasant for diabetics.



nakes a big difference



IN OBTAINING DEEPER, MORE ENDURING ANESTHESIA . . . .

It was only a minute* amount of Pontocaine which Science added to the time-tested 2% Novocain-Cobefrin solution. . . .

. . . But that very little* made a big difference . . . a difference so distinctive that it marked one of the most important advances in local anesthesia since the synthesis of Novocain itself.

Dentists were at last able to cope with those frequently encountered operative cases which had so often made obvious the inadequacy of conventional 2% solutions. Novocain-Pontocaine-Cobefrin had brought the *deeper, longer lasting, more persistent* character of anesthesia necessary for these cases. And it had done so *without increasing* either vasoconstrictor content or Novocain concentration . . . *or perceptibly decreasing* patient toleration.

**only fifteen one-hundredths (0.15) of one per cent.*

NOVOCAIN-PONTOCAINE-COBEFRIN

THE DIFFERENCE IS DISTINCTIVE

COOK-WAITE *Laboratories, Inc.*

0 Varick Street, New York 13, N. Y. . .Laboratories: Wheeling, W. Va. & Springville, N. Y.

Years of observation by our chemists and others show that while nearly all normal human perspiration is relatively free from odor as evolved, the development of odor may take place either on the skin or clothing.

For this reason MUM was specially formulated to do two important things: (1) To neutralize stale perspiration odors quickly and effectively without irritating the skin. (2) To function regardless of the type of clothing worn, and at the same time be harmless to fabrics.

A dainty, snow-white cream, MUM gives many hours of freedom from embarrassing perspiration odors. Why not try a jar of MUM today—and recommend it to your patients?

MUM

TAKES THE ODOR OUT OF STALE PERSPIRATION

A Product of BRISTOL-MYERS COMPANY, 19 L H W 50th St., New York 20, N. Y.

THE DENTIST Satisfied

SOAK

15 minutes in solution (or overnight)
1 glass water to 1 capful of POLIDENT

Hold under running water to rinse—
THAT'S ALL!

RIN

The efficiency, ease and safety of POLIDENT — the denture cleanser of proven merit — help to insure long life, proper function and spotless appearance of the prostheses you created. • Because it gently *dissolves* mucin, tarnish, and food débris, POLIDENT avoids abrasive injury to dentures, yet penetrates into the deepest and narrowest crevices, often quite impossible to reach by frictional cleansing. • It will take little of your time to explain to your patients how easy and safe it is to use POLIDENT! • Send for samples to Hudson Products, Inc., 8 High Street, Jersey City 6, N. J.

Approved for use by leading manufacturers of acrylic denture materials

...THE PATIENT *Pleased!*

DENTURES KEEP *fit* WITH

POLIDENT

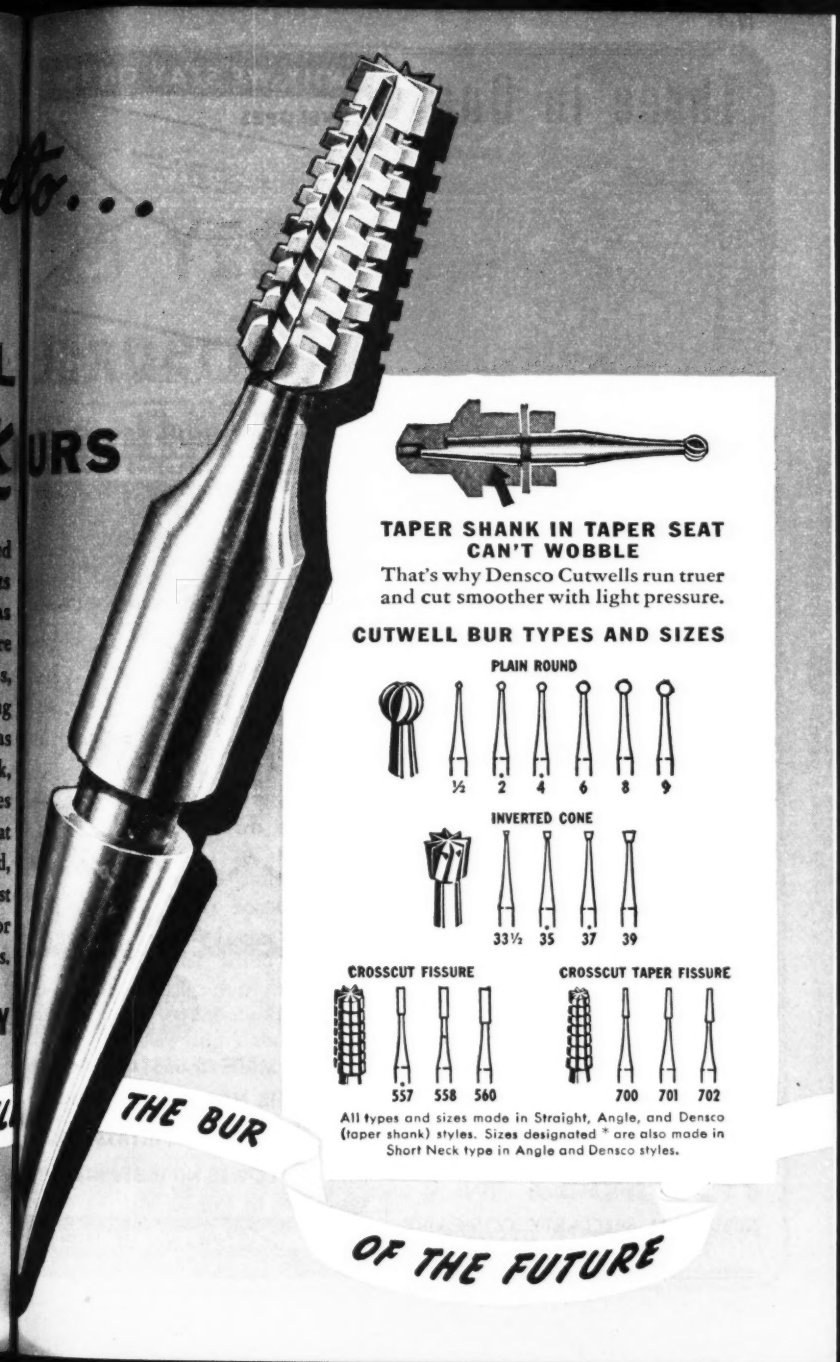
The operation was painless, but...

Abbott Procaine Hydrochloride Dental Cartridges are the choice of many expert dentists because of their uniform anesthetic effectiveness, low toxicity and minimal postoperative pain. These qualities assure the dentist of satisfactory anesthetic results without untoward and painful tissue irritation from the injected solution. Developed during nearly thirty years of practical experience in the production of procaine hydrochloride, Abbott Cartridges exceed U.S.P. standards for purity. The solutions are sterile, isotonic and adjusted to a pH that provides maximum stability. Individually labeled and ready for use in all standard dental syringes, Abbott Procaine Cartridges are readily available everywhere.

ABBOTT LABORATORIES, North Chicago, Illinois.

ABBOTT PROCAINE HYDROCHLORIDE

2% with Epinephrine 1:30,000
2% with Epinephrine 1:50,000
2% with Epinephrine 1:60,000
2% without Epinephrine
in Boxes of 10 and 100



TAPER SHANK IN TAPER SEAT CAN'T WOBBLE

That's why Densco Cutwells run truer and cut smoother with light pressure.

CUTWELL BUR TYPES AND SIZES

PLAIN ROUND

INVERTED CONE

CROSSCUT FISSURE

CROSSCUT TAPER FISSURE

All types and sizes made in Straight, Angle, and Densco (taper shank) styles. Sizes designated * are also made in Short Neck type in Angle and Densco styles.

THE BUR OF THE FUTURE

HERE'S A *Timely Suggestion*

Keep a thermos bottle of ice water on hand for use whenever you are mixing an alginate impression material. (Many dentists do this all year 'round.)

Always check water temperatures carefully *with a thermometer.* Setting time is determined by temperature, so your thermometer is your control factor—and a very important one, too.

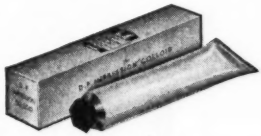
Follow the manufacturer's recommendations carefully—cooperate fully with your dental laboratory—and you will obtain uniformly satisfactory results.

DP DENTAL PERFECTION

AND FOR UNRIVALLED ACCURACY IN ANY SEASON

D-P Three-in-One Cream for Full Impression Washes, Bridge and Indirect Inlay Impressions. Registers the most minute detail. Elastic, yet possess surface hardness. Compounded to compensate for stone expansion.

D-P Elastic Impression Cream embodies the best features of Hydrocolloids and Plaster. Requires no boiling, no chilling, no special solution.

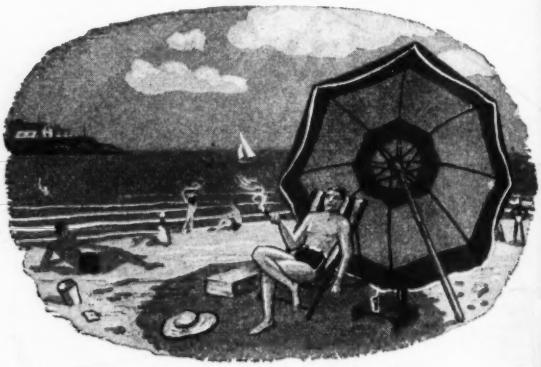


D-P Impression Colloid is unrivalled for strength, toughness and elasticity and is extremely accurate for Partial, Full and Indirect Inlay Impressions. Needs no mixing. Usable at near body temperature. Improved set on all stones and investments.

N O. 2323 W. Washington Blvd., Los Angeles 7, California

The facts about Minimax Alloy

No. 30 of a series of advertisements prepared to acquaint Dentists with the whys and wherefores of this extremely useful material.

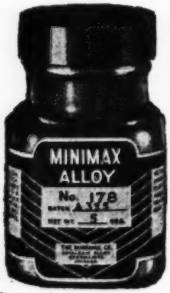


You can relax when you use *Minimax Alloy*

You can enjoy a permanent vacation from filling failures by using Minimax Alloy No. 178 exclusively in your practice. For this definitely superior amalgam alloy is fabricated for employment with your preferred technic under the conditions that are present and the variations that occur when you make fillings.

Minimax Alloy is scientifically made from start to finish—from selection of pure, electrolytically refined metals to the final step of bottling in glass that has been washed with distilled water. This careful cleanliness assures freedom from contamination.

Our employment of equipment and methods developed especially in Minimax laboratories assure Minimax Alloy's compliance with ALL specifications—not only under carefully controlled testing laboratory procedures but also when you do the mixing, condensing and finishing in your daily practice. *Buy Minimax and you can relax.*



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In 5 oz. BOTTLES	In 1 oz. BOTTLES
5 ozs. . . $1.70 per oz.	1 oz. . . $1.80
10 ozs. . . 1.60 per oz.	5 ozs. . . 1.75 per oz.
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Complies with A.D.A. Specifications. No. 1 Filings suitable for alloy-mercury gauges.

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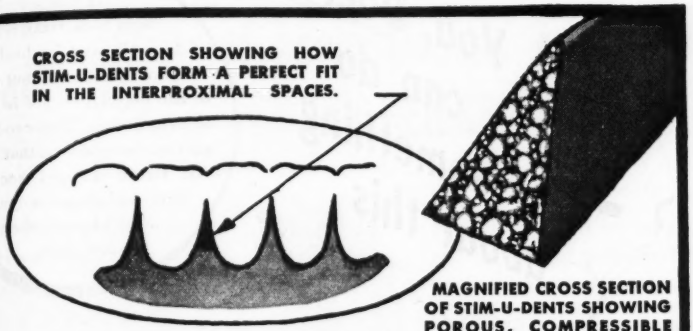

MAGNIFIED CROSS SECTION OF STIM-U-DENTS SHOWING POROUS, COMPRESSIBLE STRUCTURE.

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in the hard-to-get-at spaces between the teeth, and without injury to interproximal silicate fillings. Made of soft, tropical wood, STIM-U-DENTS are rigid enough to withstand the stress of removing debris from between the teeth, yet soft enough to avoid irritation and harmful effects. The gum tissue seems to "Glow with Health" from their daily use . . . In addition to STIM-U-DENTS' use as a routine aid in oral hygiene, their widespread acceptance by the dental profession has established them as an invaluable aid in the treatment of PYORRHEA and GINGIVITIS.

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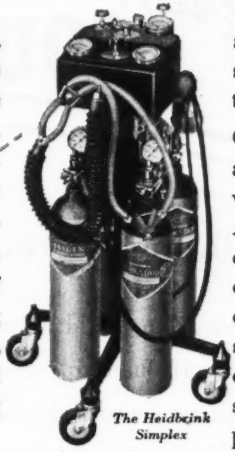
These are just a few of the reasons why thousands of dentists today are using Ohio-Heidbrink Apparatus, the modern simplified means of administering analgesia and anesthesia.



The Heidbrink Simplex

Ohio-Heidbrink equipment includes two easy-to-understand, easy-to-use machines for analgesia.

The *Heidbrink Simplex* provides all the requirements of the accepted nitrous oxid-oxygen technics for anesthesia, and for analgesia, including self-administration by the patient.

Or if you prefer to use analgesia only, the ideal way is with the *Heidbrink Airator*, an easy-to-use, easy-to-understand machine for the administering of nitrous oxid and air in suitable mixture for producing analgesia, including self-administration by the patient.

Ohio-Heidbrink products for the dental profession are available through recognized "Ohio" dental dealers, located in principal cities. Mail the coupon for complete information and booklet, "Analgesia with Nitrous Oxid."

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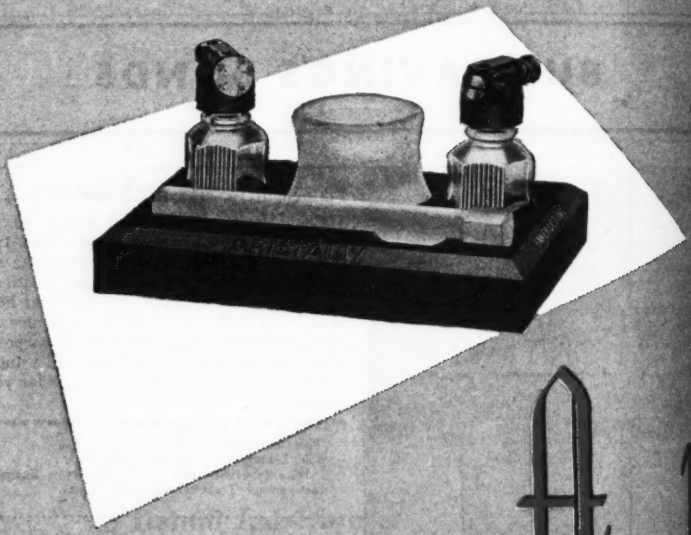

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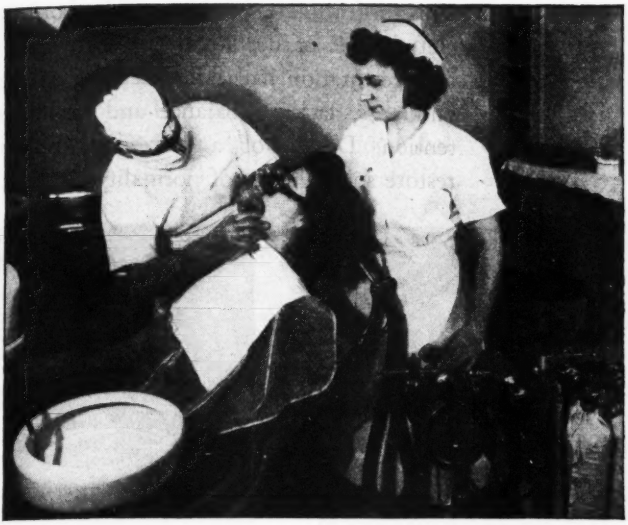

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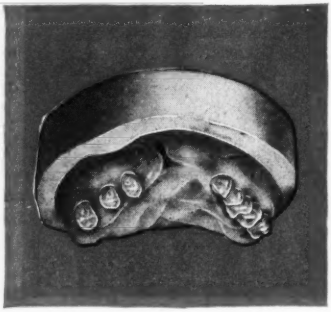
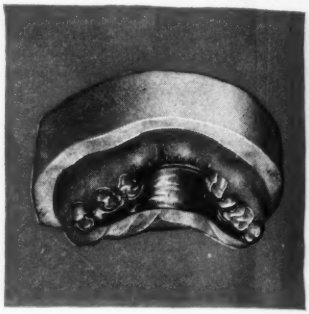
1466 *

. . . CHILD PATIENT, AGE 14

This unfortunate youngster was born with a cleft palate. Earlier attempts to provide a workable restoration had failed because of excessive bulkiness, lack of balance and insufficient retention. Design of a successful appliance to restore some degree of normality in appearance,





This was an especially difficult design problem because the teeth are small, widely spaced on the right, and tilted abnormally. Conventional clasping conditions are noticeable by their absence. To get the necessary bracing and retention, full advantage had to be taken of every undercut and retentive area. Furthermore, besides fulfilling its other functions, the restoration must also serve as a space maintainer.

Other interesting features are the way in which the case is constructed to support and retain the anterior attachment and artificial teeth superimposed on the existing anterior teeth to correct a marked prognathism. On the tissue side of the casting, retention and a finish line are provided for the acrylic attachment needed to close the nasal cavity.

The gold casting was made in NEY-ORO G-3 and weighed only 9 dwt. before the acrylic attachments and teeth were added. The success of a case such as this is dependent to an unusual degree on the exceptional casting accuracy and fit obtainable only with gold.

Twelve Similar case histories are available in a new edition of "Building a Successful Partial Denture." Write for your copy.

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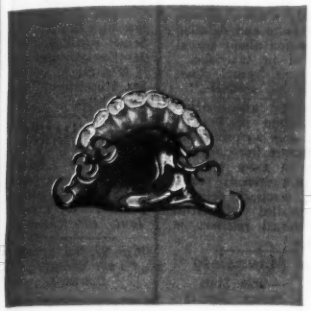
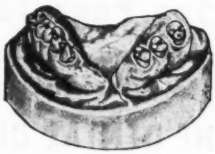
comfort and occlusion depends entirely on a positive solution to these problems. The child is now wearing her Ney Surveyor System designed gold partial with unusual pride. It seems light and comfortable to her because it has good balance, excellent adaptation and secure retention.



FOUR VIEWS OF MODEL SHOWING SURVEY LINES



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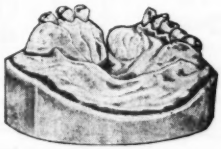

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RIGHT BUCCAL

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TECHNICAL SERVICE

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See Page 1399

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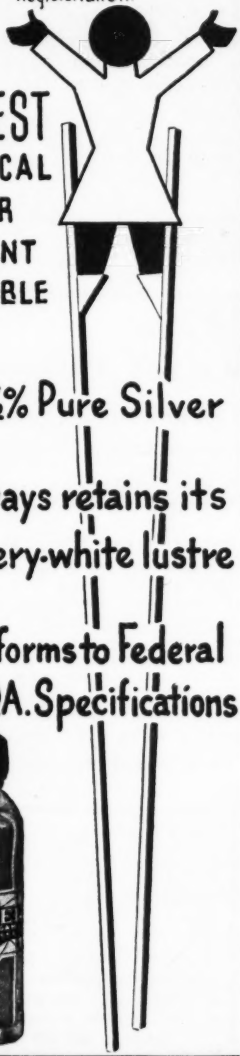

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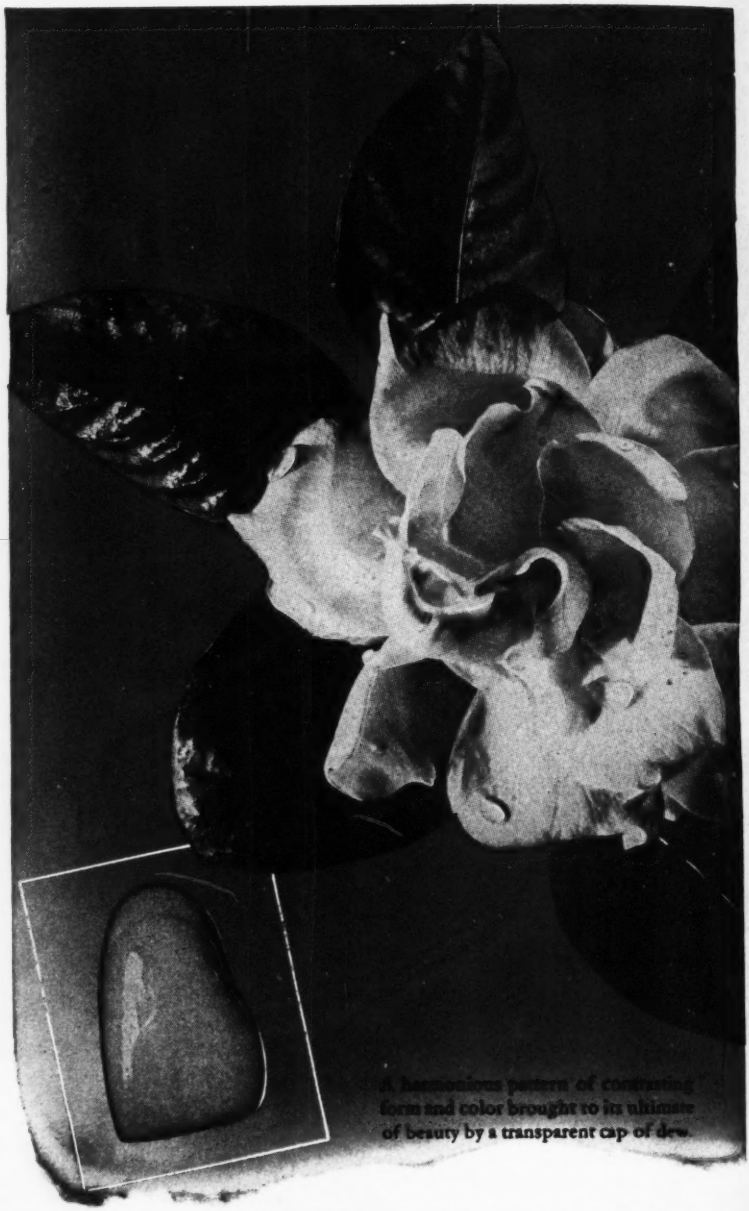

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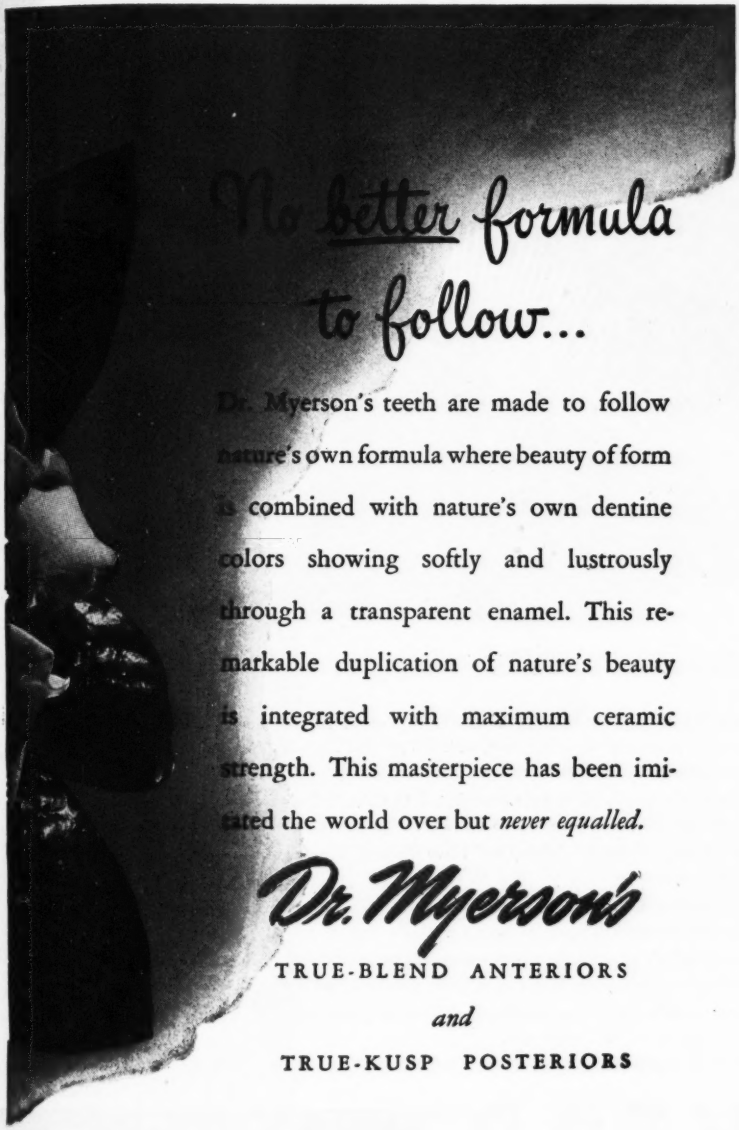

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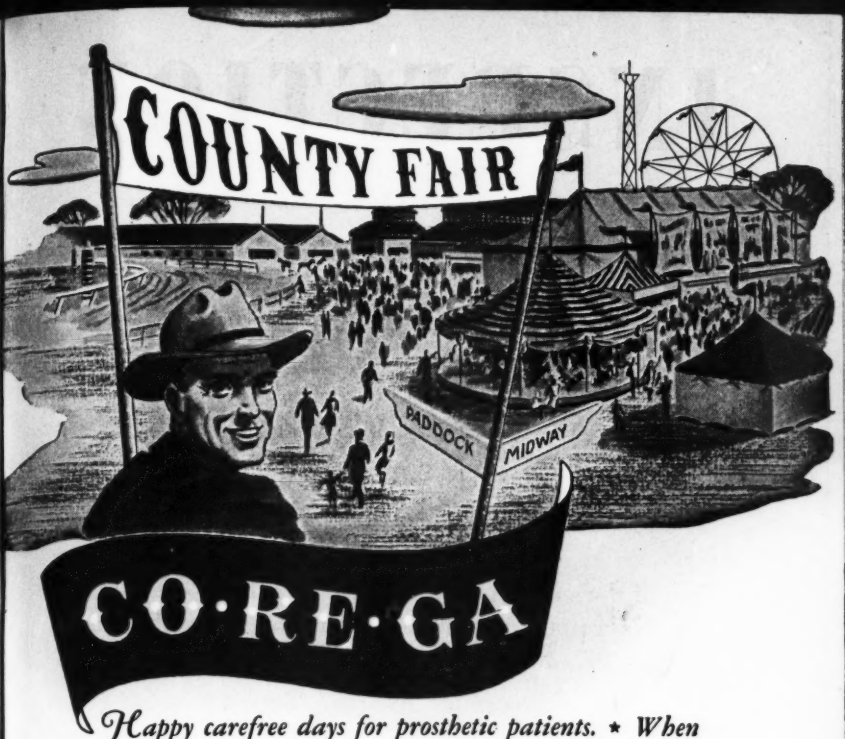

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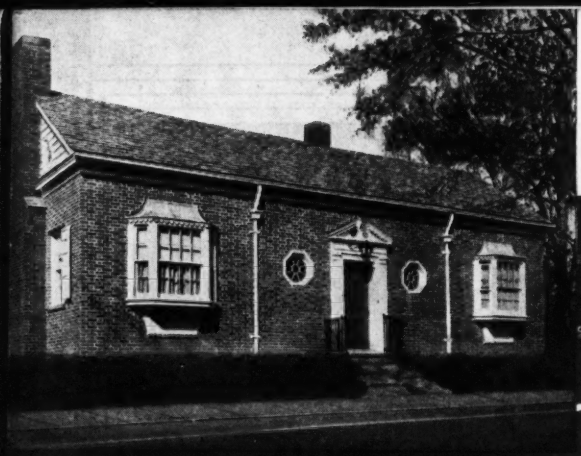
WHEELS · DISCS · LATHE WHEELS

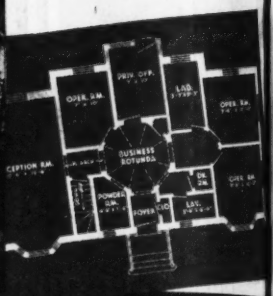
WHO'S WHO AND WHERE

Although we aim for accuracy in this index, last-minute changes often alter page numbers and positions.

PRINTED IN U.S.A.

ADVERTISING INDEX





ART: *Your* PLANNING A *Bungalow* OFFICE

Many Dentists are already planning to buy or build their own Individual Bungalow Dental Studio. They like the way these attractive locations combine the pleasant atmosphere of the residence with the efficiency of a modern, professional office . . . plus the financial and professional security of this type investment. Your Ritter dealer's knowledge of local conditions, his years of experience and sound advice are yours for the asking. See him today.

CHECK ALL 8 TYPES OF LOCATION (Described in the Ritter Planning Book). No. 4 shown here is the Individual Bungalow Dental Studio.

DELIVERIES ON EQUIPMENT: We have doubled our prewar labor force and are constantly increasing our production. Yet the overwhelming preference of veterans for Ritter equipment may cause some delay in your order. Ritter quality, preferred by the majority of dentists in America, is being maintained. *Ritter Co., Inc., Ritter Park, Rochester 3, N. Y.*

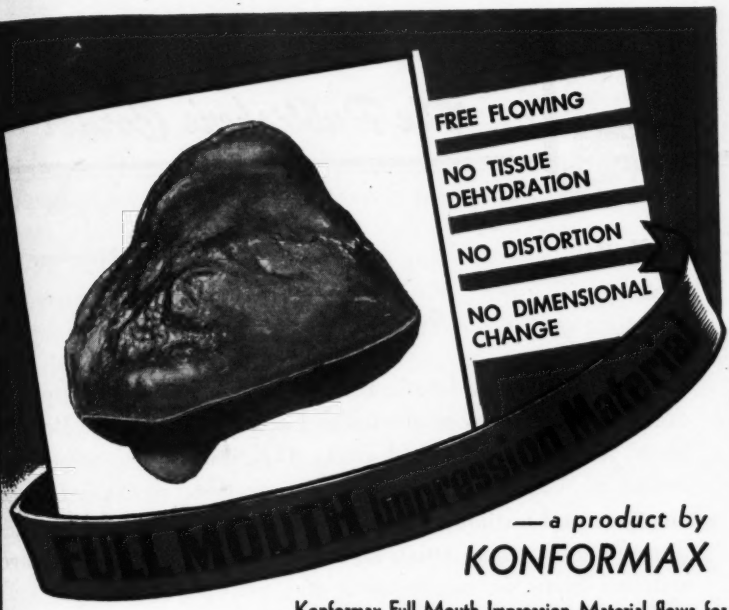
Have you read "The Danger Years"? Write us for your copy.

Visiting New York State this summer? If so, we invite you to visit our factory and see Ritter quality in production.

Ritter

BUILT UP TO A STANDARD NOT DOWN TO A PRICE

ROCHESTER, N. Y.



—a product by

KONFORMAX

Konformax Full Mouth Impression Material flows for 3½ minutes after tray is seated . . . which is sufficient time for all soft, yielding tissues to find their normal positions.

It does not dehydrate tissue. Because there is no adherence of impression to tissue, no high spots are produced in the finished denture.

Konformax Full Mouth Impression Material sets to the proper consistency at the end of 5 minutes in the mouth. No distortion of impression on removal from mouth... no dimensional change *after* removal.

Konformax impressions are not immersed in chemical solutions or in water.

Impressions can be poured any time within 30 days.

It will pay you, in many ways, to learn more about Konformax Full Mouth Impression Material!

KONFORMAX DIVISION, PERMATEX COMPANY, INC.
BROOKLYN 29, NEW YORK, U. S. A.
ORDER THROUGH YOUR DENTAL SUPPLY HOUSE

SINGLE-UNIT TUBES!
Tubes contain measured amounts for one Full Mouth Impression. Chemically treated container makes a perfect mixing cup.

KONFORMAX DIVISION, PERMATEX COMPANY, INC.
BROOKLYN 29, N. Y., U. S. A.

Send me a copy of your new folder, "Techniques for Full Lower and Upper Dentures."

NAME.....STREET.....

CITY.....STATE.....

The Publisher's Corner

By Mass **Number 303**

G.B.S. AND W.G.K.

As this is written, late in July, the magazines and newspapers are carrying numerous stories and pictures of George Bernard Shaw, who has just reached ninety. G.B.S. has yet to achieve the record of W.G.K., who died last month three weeks before his ninety-second birthday. Doctor Walter Gardner Kendall, retired Boston dentist whom Oral Hygiene told about long years ago, matched Shaw in retaining mental and physical vigor until almost his final hour. And he provided proof decade after decade that one of the basic laws of life is: it all depends. Shaw has been a strict vegetarian, a teetotaler; Walter Kendall was a famous gourmet, and, according to *The Boston Globe*, "long famous for his interesting theory that H_2O is non-potable."

Perhaps it all adds up to this: the recipe for a long and active and happy life isn't carrots and water; it isn't caviar and whisky. If anybody knows the answer, maybe it is the enthusiastic pursuit of a variety of interests. At any rate, Bernard Shaw and Walter Kendall both fit *that* pattern. So perhaps neither carrots nor caviar—nor the lubricants therefor—have had anything to do with it.

If millions know about Shaw's enthusiasms, thousands know about Walter Kendall's. He originated the Boston terrier; he was a bicycling enthusiast from the days of the old high-wheel bonebreakers; he was an accomplished horticulturist; he had a

passion for golf, for fishing and hunting (even to hunting buffalo in Montana); he loved the manly art, and baseball and horse racing and track meets. Moreover, as Jerry Nason wrote in *The Boston Globe,* Walter Kendall was a gentleman, a scholar, and a poet. It's no wonder, as *The Globe* says, that he was "one of Boston's best-loved figures."

His July first birthday parties were a New England institution: practically nobody stayed away. Walter Kendall's friend and my own, John McGowan, has sent me the doctor's ninety-first birthday party invitation. It read:

WHAT DO YOU MEAN—91?

As sure as 9 and 1 make ten,
I am a centenar-he-hen;
And so I am inviting you
To help me cock-a-doodle-doo.
'T will happen on July the First,
So come along and bring your thirst;
Just put the cat out, wind the clock,
and head this way—

Yours truly,
"Doc"

Down at the bottom there's a line reading: "91 plus 9 equals 100," and a cartoon of "Doc" pedaling a high-wheeler, chasing Father Time.

On the eve of his ninetieth birthday party, he was having some trouble with his eyes, but Doc Kendall's gay courage took care of that. "I can still read out of *one* of them," he said with a grin as he finished setting out 125 tomato plants.

VETERANS' CLEARINGHOUSE

ORAL HYGIENE will continue to print free want ads to aid returning Dental Corps veterans. Please use the symbol pre-

ceding each in writing to the CORNER about them. (*See also page* 1674).

BB—Qualified young orthodontist seeks pleasant city of 35,000 or more population where he can settle down and practice. Licensed at present in New York.

BC—Texas dentist has new pre-war equipment for sale: Weber chair, cabinet, Pelton cuspidor, Castle lights. Also information on good location.

BD—Florida-licensed dentist wanted for West Palm Beach Kiwanis Dental Clinic; salary, $350; to operate only during school hours; may use clinic facilities for part-time practice; stay six months, or longer if desired; excellent opportunity for veteran or recent graduate while seeking permanent location, or wishing to spend winter in Florida.

BE—Optometrist is willing to share his office with ambitious veteran dentist with New Jersey license. Partitions and plumbing already installed; would make rent attractive. Is located in good business section of large city.

BF—New York-licensed veteran dentist, young and personable, seeks position with ethical, busy practitioner. Experienced prosthetics, fixed bridgework, and jacket crown restorations. Minimum salary expected, five hundred dollars per month.

BG—Illinois practice wanted by veteran Navy dentist, age 34, graduate class of '35. Desires association or purchase of practice.

BH—Practice wanted by recently discharged Coast Guard dental officer. Interested in established practice in either Long Island or Westchester County. State location, type and condition of equipment, and price.

BI—For sale: modern, fully equipped, and well-established dental office in excellent location. Lease, low rent at $40 a month. Moving to California. Address replies to Dr. A. D. Witnauer, 1377 Main Street, Buffalo, N.Y. Telephone: LI 2559.

SAY, MISTER! WANNA BUY A DIAMOND, CHEAP?

Available in straight handpiece, latch type and taper type shanks

YOU wouldn't take a chance on a "bargain" diamond from an itinerant peddler! It is also to your advantage to use the same good judgment in buying the diamond dental instruments that play such an important part in modern cavity preparation.

The combination of **DENSCO** Precision Handpieces and **DENSCO** Blu-White Diamond Instruments—each supreme in its own field—results in cutting speed, accuracy, patient-comfort and overall economy of operation never before attainable. Ask your salesman to show you the complete Blu-White line. It contains many instruments not made by other manufacturers.

DENSCO Blu-White Diamond Instruments Are Sold Only Through Dealers...

DENSCO

The DENTAL SPECIALTY MFG. Co.

BOX 420 - DENVER - COLO.


THE
Supreme
NON-TOXIC
Anesthetic
OINTMENT
for
PRURITUS ANI
PRURITUS VULVAE
PRURITUS SCROTI
and
FOR ALL OTHER MINOR SKIN IRRITATIONS IN WHICH SEVERE ITCHING, BURNING AND PAIN ARE THE PREDOMINANT COMPLAINTS.
DERMA MEDICONE
DERMA MEDICONE
DERMA MEDICONE
DERMA MEDICONE exerts a soothing effect on the muco-cutaneous area of the ano-rectal tract—thus breaking the vicious circle of itching-scratching-infection. Within five minutes after application, the suffering patient is fully relieved of distress and discomfort.
MEDICONE COMPANY
225 Varick Street
New York 14, N. Y.

ONE
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after
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fort.
PANY

GETZ-400

Dual-Purpose IMPRESSION PASTE

FOR PRESSURE OR NON-PRESSURE TECHNIQUES

REVOLUTIONARY IN RESULTS

with a simplified procedure that produces a smooth, creamy, non-granular mix . . . unequalled by any other full denture impression paste.

TEMPERATURE DEFIED

No worry about heat or cold inside or outside the office. Setting time is positively controlled allowing 30 seconds to complete the mix with impression set in next 4 minutes.

NOT STICKY

Excess of material is easily and quickly removed from patient's face or operator's hands by simply wiping off with a towel.

DUAL-PURPOSE

For non-displacement of tissues, use mix immediately. For displacement of tissues, hold mix in tray for a few seconds to allow paste to slightly congeal.

SETTING IS COMPLETE

When impression is withdrawn and touched, no sticky or surface residue adheres to the fingers.

NO DISTORTION

Does not crystallize or become brittle in setting. Because this paste has resilient as well as resistant qualities, the impression will spring over undercuts and spring back with accuracy.

SAFE TO HANDLE

The finished impression has a very smooth surface and no surface detail can be lost through sticking of wrapping when sending to the laboratory.

GUARANTEED? . . . OF COURSE

You may test this paste by using it on several impressions with the privilege of returning unused portion for full credit refund.

1 Package, $3.00 **6 Packages, $2.70 ea.**

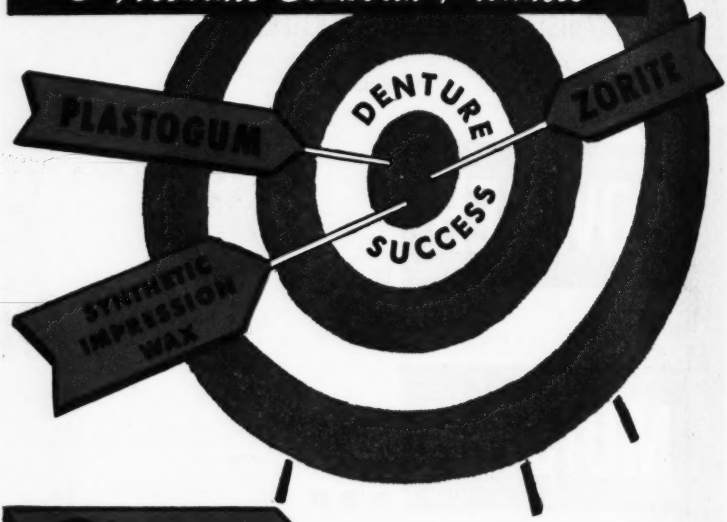
Order from your dealer

THE WILLIAM GETZ CORPORATION
7512 GREENWOOD AVE. CHICAGO 19, U.S.A.

for your preferred

CORRECTIVE WASH TECHNIC

3 Accurate Bosworth Products



Plastogum for *exact* registration of the finest detail. Mixed with water, Plastogum has a putty-like consistency. The setting time is controlled to assure best possible results in muscle trimming. May be used with full compound and in full plaster technique; also in final impression with patient biting into centric occlusion. Highly recommended for Dr. McGrane procedure.

Zorite — a bland resinous impression cement with many uses. Zorite is ideal for securing corrective wash. It is particularly excellent for the difficult lower and mucostatic impressions.

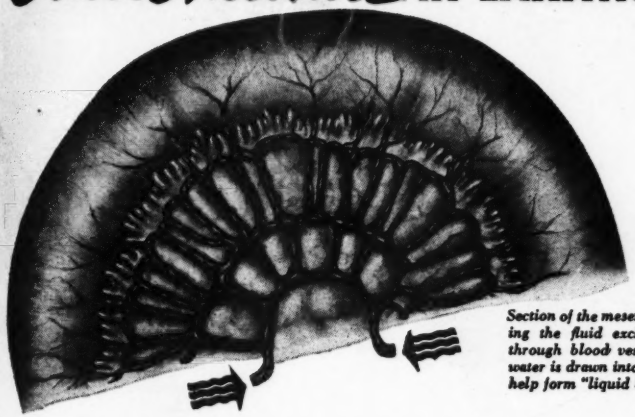
Synthetic Impression Wax It may be painted on compound or baseplate trays as a corrective wash. Provides rounded, smooth and full functioning peripherals and post-dam without overtension. Accurately registers hard or soft areas. Has great flow under pressure and automatically relieves hard areas.

THRU YOUR DEALER

HARRY J. BOSWORTH COMPANY

1315 SOUTH MICHIGAN AVENUE • CHICAGO 5, ILLINOIS

DENTISTS PREFER *Gentle Pressure* IN LAXATION



Section of the mesenterium showing the fluid exchange system through blood vessels whereby water is drawn into the bowel to help form "liquid bulk."

For years SAL HEPATICA has been the choice of many dentists for gentle yet thorough laxative action.

Added to water, SAL HEPATICA makes a sparkling saline solution that follows nature's own methods—utilizes the gentle pressure created by "liquid bulk" to stimulate peristalsis.

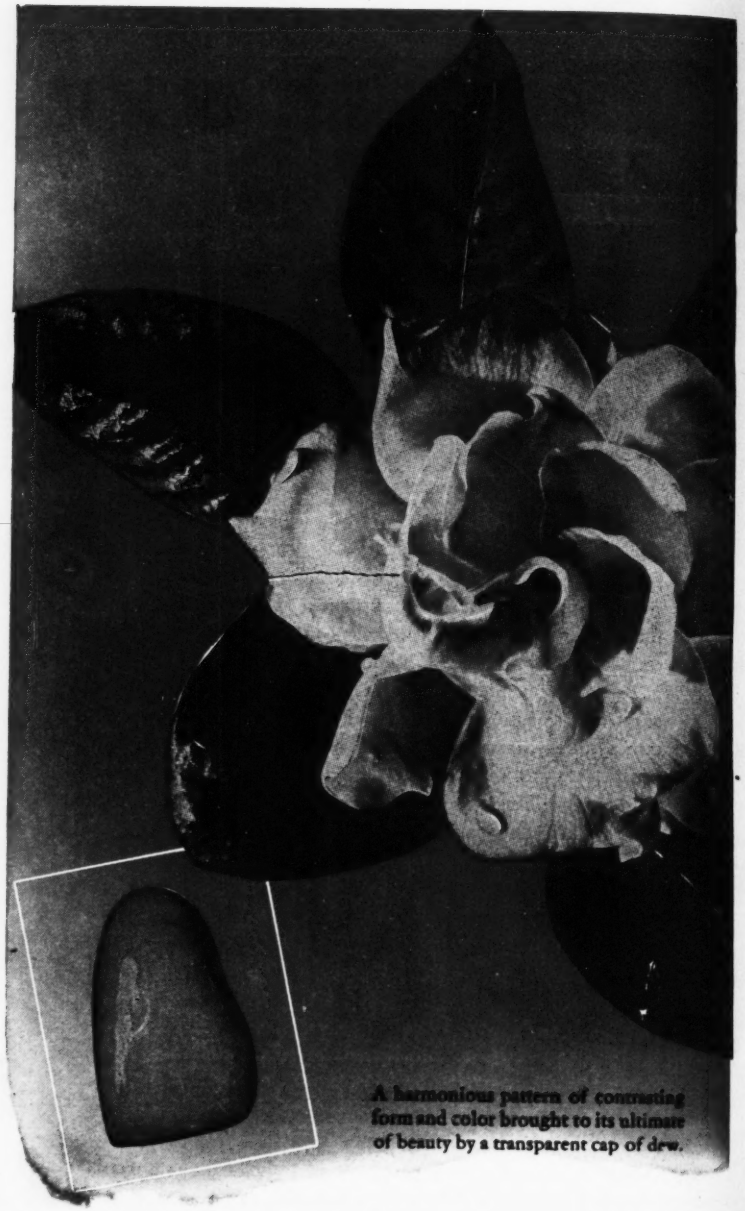
This "liquid bulk" flushes the intestinal tract and gently but effectively cleanses it of undesirable waste. In most cases relief comes quickly, usually within an hour.

SAL HEPATICA is simple to administer, pleasant to take, and prompt in yielding a response. Its gentle pressure can be depended on to relieve constipation without irritation.

SAL HEPATICA

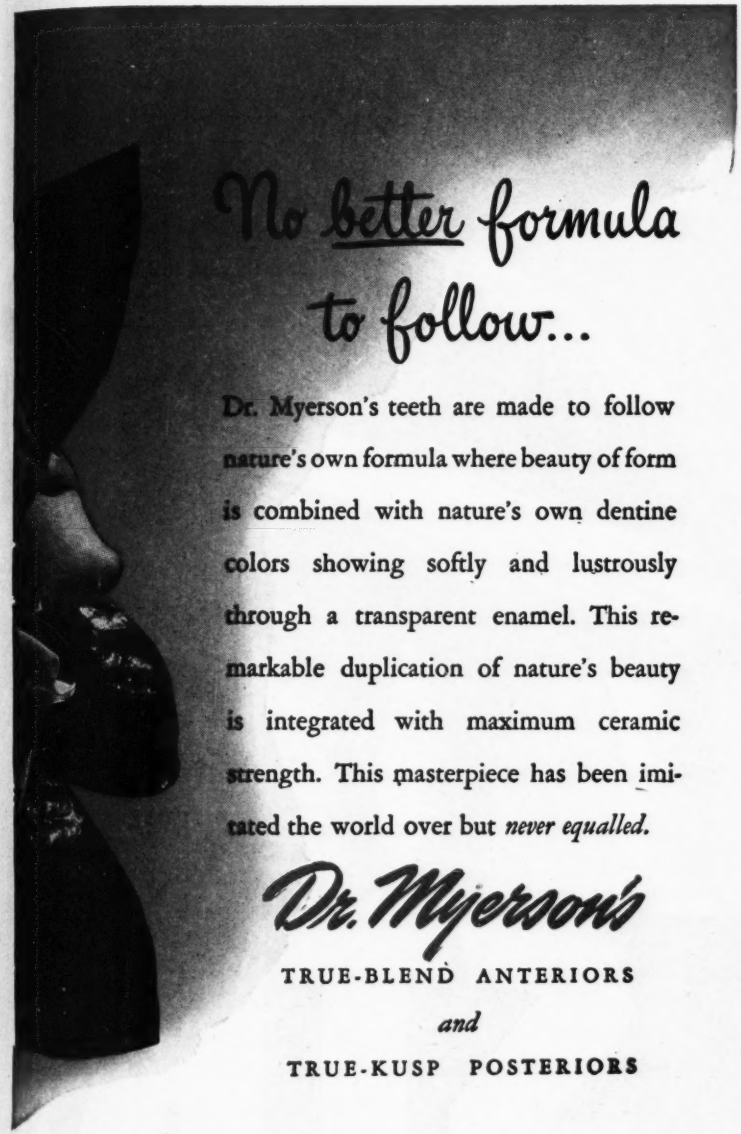
A Product of BRISTOL-MYERS COMPANY
19 L West 50th Street • New York 20, N. Y.

GENTLE PRESSURE FOR GENTLE YET THOROUGH LAXATION



A harmonious pattern of contrasting form and color brought to its ultimate of beauty by a transparent cap of dew.

IDEAL TOOTH INCORPORATED



No better formula to follow...

Dr. Myerson's teeth are made to follow nature's own formula where beauty of form is combined with nature's own dentine colors showing softly and lustrously through a transparent enamel. This remarkable duplication of nature's beauty is integrated with maximum ceramic strength. This masterpiece has been imitated the world over but *never equalled.*

Dr. Myerson's

TRUE-BLEND ANTERIORS

and

TRUE-KUSP POSTERIORS

CAMBRIDGE 39, MASSACHUSETTS


STRE

The even balance and sum total of all of the various types of strength in Vernonite including *tensile, compression, shear, impact* and *transverse* strength combine to form the very desirable quality of *toughness.* This "toughness" is achieved through the special chemical composition of Vernonite, which is unique in the field of acrylic denture materials. It is assured by the scientific methods used in compounding its ingredients.

VERNONITE DENTURES ARE TOUGH

Tough is defined as "strong or firm in texture, but flexible and not brittle; able to endure strain, hardship." Dentures possessing this property will carry maximum loads; they will yield under mastication without fracture; they won't chip. They can be sprung off models. They will withstand any stresses applied in mouth service without breakage.

Prescribe VERNONITE, the nation's first and most honored acrylic denture material, for STRENGTH and lasting satisfaction.

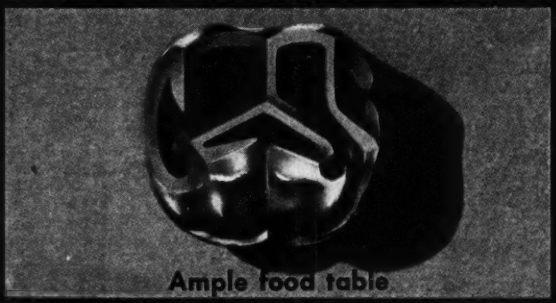
VERNON-BENSHOFF COMPANY

P. O. BOX 1587 • PITTSBURGH 30, PENNA.

No. 5 of a series of advertisements discussing the various types of strength possessed by Vernonite.

functional design

meets edentulous requirements

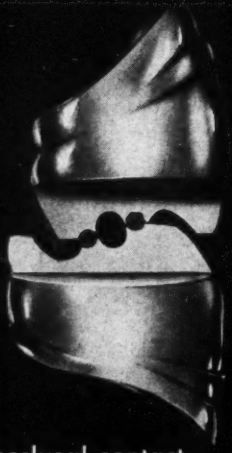


Ample food table

Five exclusive features of Trubyte New Hue 20° Posteriors that insure comfortable, efficient mastication:

1. Interacting fine knives
2. Ample food table
3. Adequate clearance ways
4. Narrow occlusal contact
5. Relatively low cusps

The narrow occlusal contact of Trubyte New Hue 20° Posteriors reduces the force required to crush and shear food; and thus increases the effectiveness of the teeth in mastication. The reduction of force minimizes pressure on the underlying ridge and adds to the patient's comfort with dentures.



Narrow occlusal contact

Interacting fine knives

Nature's basic principles for comfortable, efficient mastication have been incorporated with full recognition of edentulous requirements in Trubyte New Hue 20° Posteriors. Use any technic you prefer, their efficiency is always maintained.

TRUBYTE NEW HUE

20° POSTERIORS

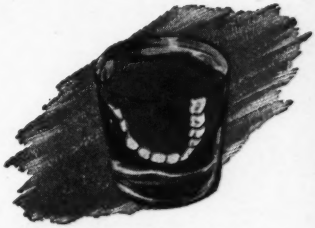
START THE PATIENT RIGHT...IT'S

DENTURES KEEP *fit*

...ER (AND YOUR) *Advantage*

MANY DENTISTS find it wise to show the patient (before leaving the office) how easy and safe it is to keep the new denture in perfect condition with POLIDENT. Many later complaints can thus be easily avoided . . . complaints of irritation from plates worn by brushing with abrasive cleaners, of offensive odor due to undissolved mucin plaques, and of unsightly discoloration. . . . Furthermore, the danger of chipping or breaking is materially reduced, because of the minimum handling necessary with POLIDENT.

...UDSON PRODUCTS, INC., JERSEY CITY 6, N. J.



SOAK

Soak 15 minutes in solution (or overnight)

(1 glass water to capful POLIDENT)

RINSE

Hold under running water to rinse—

THAT'S ALL

...pproved for use by leading manufacturers of acrylic denture material.

...ITH POLIDENT

Time-tested Revelation Tooth Powder has always proved worthy of your confidence. Safe, efficient, pleasant for natural teeth; also ideal for brightening orthodontic appliances and dentures, including acrylics. Thousands of dentists recommend Revelation. We invite you to test it at our expense. *Please include professional stationery with your request for sample.*

Revelation TOOTH POWDER

AUGUST E. DRUCKER CO
2226 Bush St., San Francisco 15

( ) *Send full size can for personal trial*

Dr._____

Address_____

City_____ Zone____ State_____

IN ALL-METAL CANS. Original flavor retained

OH-44

The doctor makes his rounds

● Wherever he goes, he is welcome . . . his life is dedicated to serving others. Not all his calls are associated with illness. He is often friend and counselor . . . he is present when life begins, watches it flourish and develop. His satisfactions in life are reflected in the smiling faces of youngsters like this one above, and of countless others whom he has long attended.

Yes, the doctor represents an honored profession . . . his professional reputation and his record of service are cherished possessions.

According to a recent independent nationwide survey:

MORE DOCTORS SMOKE CAMELS

than any other cigarette

R. J. Reynolds Tob. Co., Winston-Salem, N. C.

S.S.WHITE

KRYPT

New

EASY TO MIX • EASY TO USE

For Cementing Acrylic and Porcelain Crowns, Inlays and Facings; Gold Crowns and Inlays; and all cementing operations, where color and translucence are desired. Kryptex is strong; oral fluids do not affect it; it holds fast.

Make a test - - - order a Kryptex New User Package today

Satisfy yourself with the merits of Kryptex by using the generous trial portions of powder and liquid in the New User Package. If results prove other than successful return the remaining powders and liquid intact for cancellation of the package charge.

S. S. WHITE GERMICIDAL KRYPTEX

Kryptex with 0.2% ammoniated mercury. For cementing orthodontic bands, filling deciduous teeth, etc., where an effective germicide is indicated. Much more potent than the silver or copper cements. Light yellow only.

Powder (14.2 grams) . . $2.00 Liquid, per bottle . . $1.00

Orthodontist Package: 42.6 grams Powder and 2 bottles liquid $7.00

Prices Subject to Change Without Notice

PLACING QUALITY ON TRIAL

EX

llser Package

CONTENTS:

4 full portion powders (14.2 grams each)
(Powder Nos. 1-3-6-9)

1 full portion bottle liquid

1 trial powder No. 3

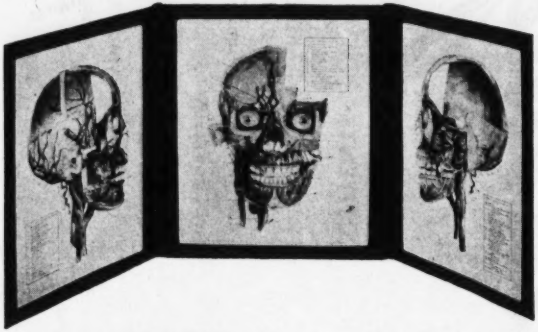
1 trial bottle liquid

VALUE $9.00

PRICE $7.50

THE S. S. WHITE DENTAL MFG. CO.
Philadelphia, Pa.

L- WITHOUT EXPENSE TO YOU



Now available at your request

"THE NERVE DISTRIBUTION & BLOOD SUPPLY OF THE HEAD"

A SIX-PAGE FOUR-COLOR FOLDER

Since this full-color *costly* and *exclusive* feature appeared in the October, November, and December 1945 issues of *The Dental Digest* we have received *many requests* for chart is easily detachable for framing since there is no material printed on the reverse side with the exception of the title page.

and December 1945 issues of *The Dental Digest* we have received many requests for chart is easily detachable for framing since there is no material printed on the reverse side with the exception of the title page.

The charts showing in complete detail the nerve distribution and blood supply of the head, with explanatory copy, will be invaluable for your operatory. This series will be of special help in explaining dental conditions to patients.

The price of this six-page folder is only $1.00 to regular subscribers of The Dental Digest. It is also available to new subscribers in combination with a special sixteen-month subscription. Order your copy today . . . use the convenient coupon.

THE DENTAL DIGEST
1005 Liberty Avenue, Pittsburgh 22, Pa.

☐ Here is $1.00 for a copy of "The Nerve Distribution and Blood Supply of the Head." I am a regular subscriber.

☐ I am not a subscriber. Enter my subscription for sixteen issues of The Dental Digest, including the charts mentioned above, for $3.00.

Dr. .....

Address .....

City .....

Dealer .....

STARLITE *Diamond Instruments*

GIVE SUPERL

ONLY STARLITE HAS THE

"STARLITE TAGSEAL"

You can now be sure that the Diamond Instruments you order are the original, made-in-America STARLITE Diamond Instruments. Each one has the "STARLITE TAGSEAL" here illustrated. If your regular dealer can't supply you, write us. We shall gladly furnish names of other dental supply houses that can.

TIVE SERVICE

STAR DENTAL

BETTER FOUR WAYS

Highest Quality Diamonds. Only the highest grade South African diamond bort is used in STARLITE *Diamond Instruments.* A secret imbedding process binds the diamonds into an abrasive cutting surface of exceptional evenness and durability.

Mechanical Perfection. Your STARLITE *Diamond Instruments* are unconditionally guaranteed against mechanical imperfection. They're minutely balanced—never get "off center".

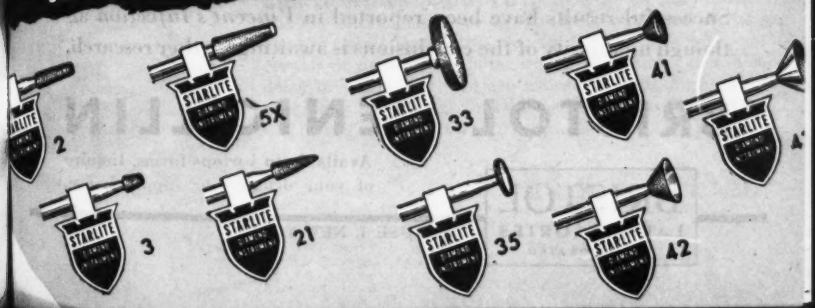
Precision Control. These superior mechanical features enable you to exercise precision control without physical strain or nervous tension in every preparation procedure where the use of STARLITE *Diamond Instruments* is indicated.

Largest Variety. STARLITE *Diamond Instruments* come in more sizes and shapes and provide more varied applications than any other kind. Combined, these leadership advantages continue to make them—

THE INSTRUMENTS OF THE PROFESSIONAL PERFECTIONIST

STAR DENTAL MFG. CO., INC.

58th & MARKET STREETS • PHILADELPHIA 39, PENNA.



Have You Thought About a *Professional Studio?*

The Professional Studio, owned by several dentists or a combination of dentists and physicians, is becoming increasingly popular—especially for group practice. Note how the Studio shown above meets the specialized needs of a dentist and three other professional men—and still provides ample room for expansion.

ASK YOUR RITTER DEALER ABOUT ALL 8 TYPES OF LOCATION (shown in the Ritter Professional Office Planning Book). Number 5 is the Professional Studio.

EQUIPMENT DELIVERIES—Ritter production is steadily increasing—we've doubled our prewar labor force to help speed deliveries. Yet the overwhelming preference of dentists for Ritter equipment may cause some delay in your order. We are maintaining the high quality which has made the majority of dentists prefer Ritter. *Ritter Company, Inc., Ritter Park, Rochester 3, N. Y.*

Have you read "The Danger Years?" Write us for your copy.

Ritter

BUILT UP TO A STANDARD NOT DOWN TO A PRICE

ROCHESTER, N. Y.